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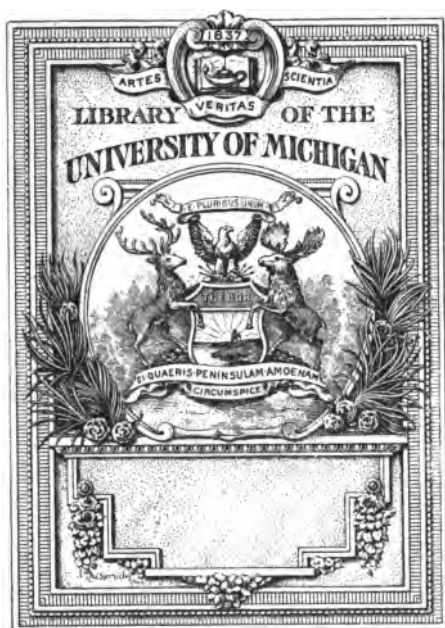
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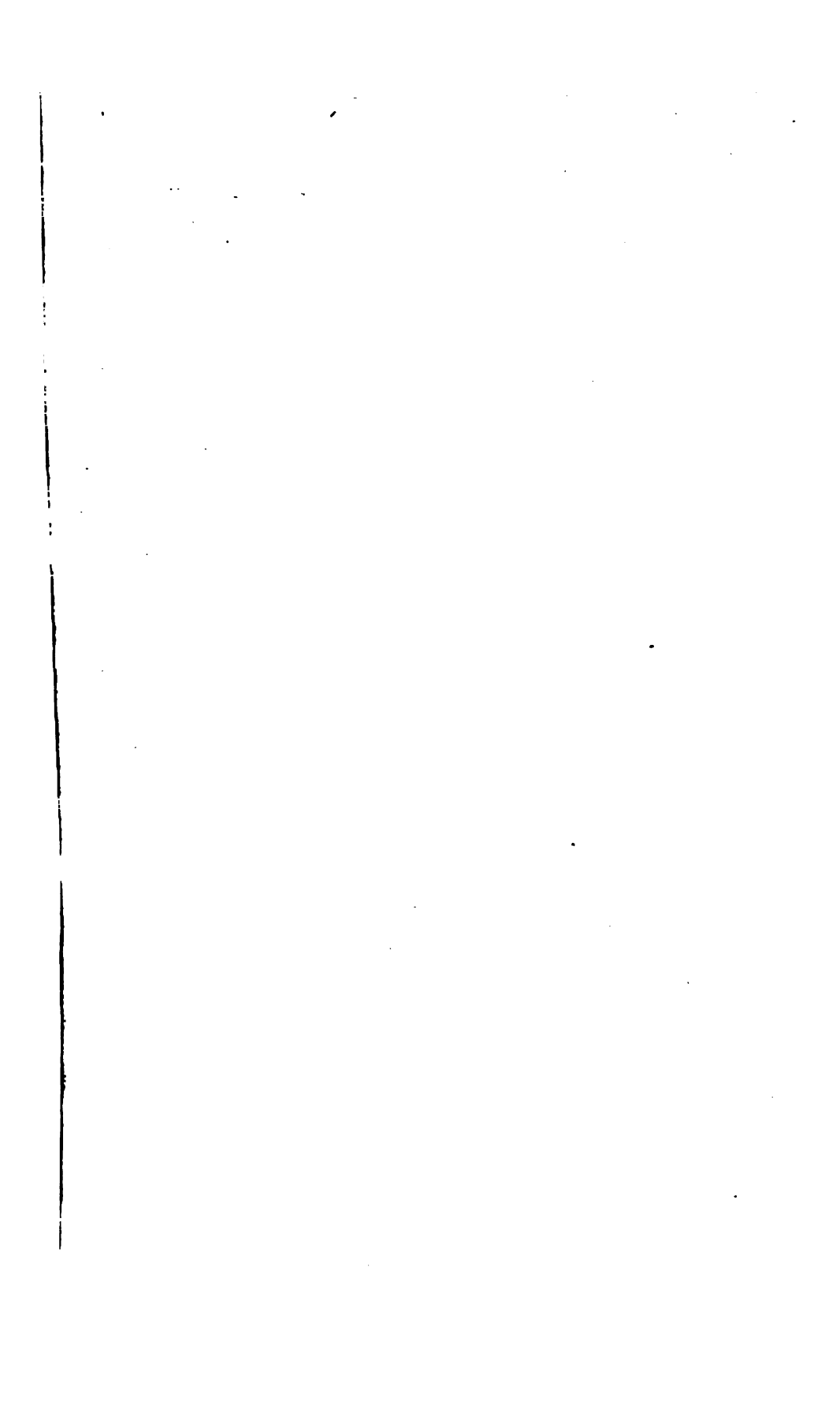
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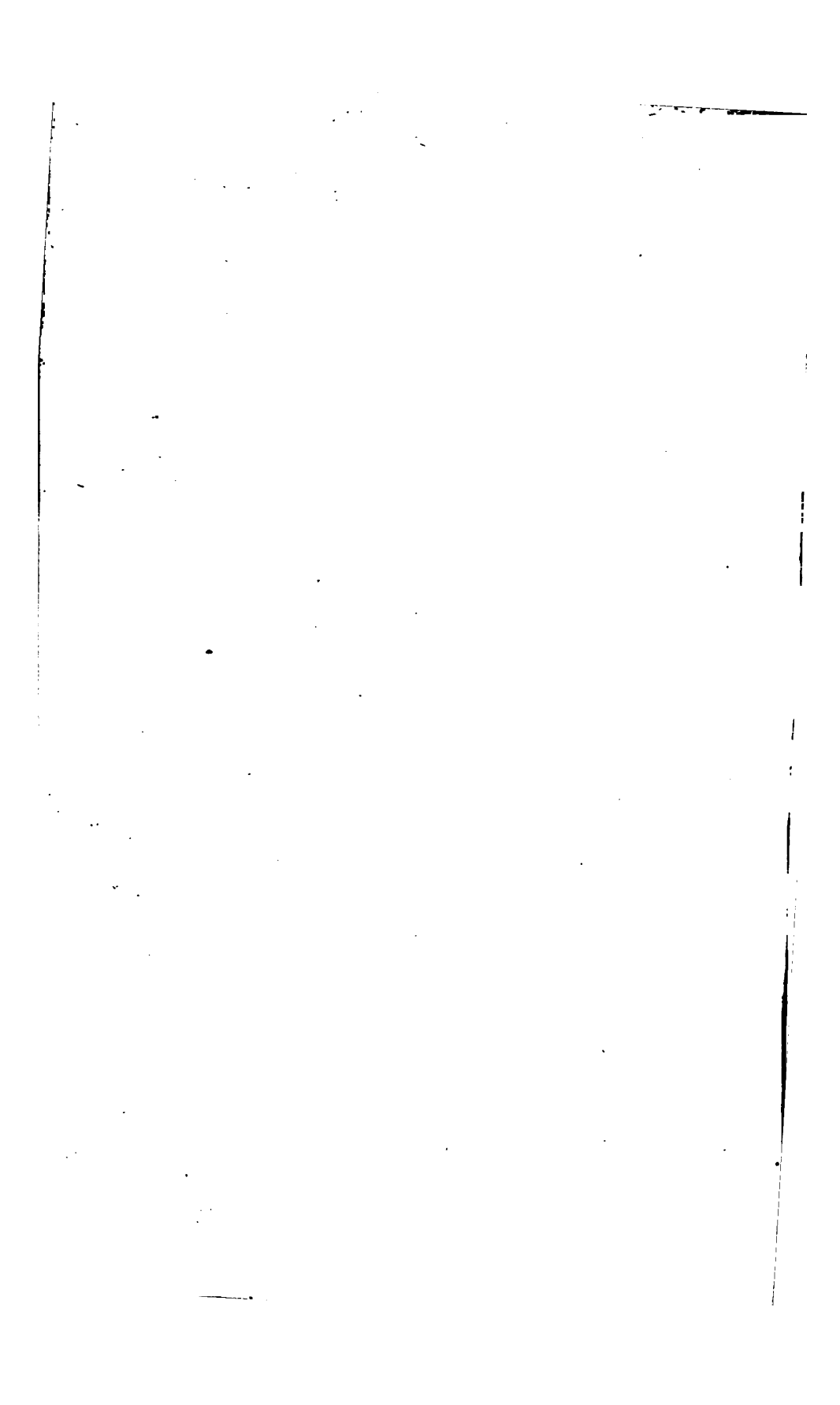
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COMMUNICATIONS.

*THE IMPORTANCE OF EARLY OPERATIONS IN SURGICAL INJURIES.**

BY R. HARVEY REED, M. D., MANSFIELD, O.

The importance of early operations in surgical injuries is annually becoming more apparent.

The old theory of delaying operative interference until after reaction has been established, is gradually losing precedence.

It is the surgeon's imperative duty to save life, relieve pain and suffering, and give the best possible results by operation or otherwise his skill will permit.

The question then arises as to which method will accomplish these results the most effectively, early operations in surgical injuries before reaction has been established, or delayed operations, after the shock has entirely subsided?

We are well aware of the instructions of surgical authorities for ages past on this subject, forbidding operative interference until after reaction has been established; which has been handed down from generation to

*A paper read before the Forty-first Annual Meeting of the Ohio State Medical Society, held at Akron, O., June 2, 3, and 4, 1886.

generation with almost infallible precision; yet notwithstanding we believe that the day for such instructions is past, and that this time-honored practice should only apply to the exception now as rigidly as the exception applied to this ancient rule in the past.

We have had no doubt of the advisability of delay until after reaction was established, prior to the discovery and use of anesthetics, or even now when chloroform or bromide of ethyl is used for obtunding the senses; but when ether is the anesthetic used, we do question the propriety of delay as a rule, under the circumstances.

What are the claims for delay, and the objections to prompt operative interference?

They are, chiefly, that the additional injury sustained by the operation will increase the shock and general depression, and thus hazard the patient's life.

Does practical experience in surgery warrant these claims as surgery is practiced to-day?

Whilst it may have warranted these claims when operations were performed without the aid afforded by the use of ether, nitrite of amyl, the hypodermic and antiseptics, it certainly does not warrant them when they are judiciously used.

Instances are by no means uncommon where a mangled arm or leg, which has had the life actually crushed out of it by massive machinery, will prolong the shock, which a prompt amputation even without any anesthetic will greatly mitigate.

It is a notable fact that when ether is used under such circumstances, the pulse will even improve and the temperature of the extremities rise, in the very midst of an operation, as I have witnessed time and again on the operating table, which changes are most marked after the mangled member has been removed.

That large masses of partially or wholly devitalized tissue have a depressing effect on the economy, and thus retard reaction, has long since been recognized by surgeons, and is readily demonstrated in the experimental laboratory.

Erichsen, speaking of shock, says on page 107: "In some cases, however, the presence of a crushed limb appears to prolong the shock, and thus prevents the patient rallying, notwithstanding the administration of stimulants. Under these circumstances, the surgeon would be justifiable in operating before reaction came on."

Ashhurst, on page 137, says: "In some instances, however, especially in the cases of compound fracture produced by railroad or machinery, the mangled limb seems by its presence to act as a continual source of depression, and in such cases prompt amputation, even during the existence of a certain amount of shock, will give the patient a better chance than delay. Particularly is this the case when the injured part is very painful, and when the bleeding is going on from small vessels that cannot be controlled."

Agnew, in Vol. II, page 383, says: "There can be no objection to adjusting a broken limb, the malposition of which must, by causing pain, add to the severity of the shock. Nor would it be wrong to control the hemorrhage of a wound, even if in doing so it became necessary to cut down upon and expose a large arterial trunk. The collapse which sometimes follows incipient strangulation of an intestine can be no bar to performing an operation for the relief of hernia, as *only* by doing so can we hope to remove the shock. The same may be affirmed with regard to a compound depressed fracture of the skull with shock; the bone should be elevated as an essential part of the removal of collapse."

Again he says: "There are some who think that in prolonged shock, rather than allow the case to pass beyond the limits of the primary period, it is better to operate, even during imperfect reaction. There can be little doubt of the correctness of this opinion."

"A great deal has been said about the choice of time for performing an operation." "No doubt," says so conservative a surgeon as Mansell Moullin,* "each case must be judged on its merits—the main guide, of course, is the severity of the shock sustained, as evinced by the patient's pulse and general condition. If it is not severe it need scarcely be regarded; if so grave that it is questionable whether reaction *can* set in, every means should be tried to bring the patient around *before* operation is attempted."

Thus from high authority we learn of two conditions at least, in which early operations in surgical injuries are generally agreed upon and advised, viz.: those in which the shock is but slight, and those in which the shock is grave and prolonged.

As to the former there can be no question, and as to the latter, experience has long since demonstrated the advisability of such practice, which time after time has proven successful; then why should we be

* International Encyclopedia of Surgery, by Ashhurst, Vol. I, page 374.

inclined to stick to the old "time honored" custom of waiting for reaction to set in before we operate ?

If patients not only live but do well, who are operated on while under the influence of shock, who are so mangled as to prevent reaction altogether, without any operation for their relief, as well as those who suffer but little from shock, then why not operate upon those who are between the two extremes, without waiting for reaction to be established ?

For my part I can see no practical reason for delay, but on the contrary can see several practical reasons in favor of early operations, when an operation is necessary at all.

The presence of a mass of crushed flesh or shattered bones, which is rapidly becoming moribund, in which the circulation has been largely interrupted, the nerves pulpified, and the flesh mangled, is a decided factor in prolonging shock and depressing the vital powers of the system, which prompt removal will as promptly relieve.

Indeed, I have seen patients who were almost pulseless, with cold extremities and labored respirations, when an operation was begun, revive, as it were, almost as soon as the mangled limb was removed ; the pulse becoming decidedly stronger, a return of heat to the extremities, with improved respiration, which condition would continue, with scarcely a perceptible interruption after the withdrawal of the ether, after the operation.

Even in double amputations, which are to be much more dreaded than the single, I have operated during shock, and witnessed the same gratifying results.

The use of ether quiets the nervous system and supports circulation as well as deadens the patient's sensibilities, and thus acts as a decided factor in establishing the desired reaction.

It must be remembered, however, this is not the case when chloroform or bromide of ethyl is used ; whilst they quiet the nervous system, and benumb all the sensory nerves, they at the same time reduce the heart's tension, which has already been reduced much below normal by shock, which now needs just the support ether furnishes it in its embarrassment, and not the depression produced by the former, which should be strenuously avoided, or if given at all, not used until after complete reaction has been established.

The natural dread of a pending operation has a marked depressing effect on those who, from a sudden and unexpected force of circumstances, are compelled to submit to such a procedure, who cannot help from

worrying more or less about it, and thus retard reaction, and fatigue themselves mentally, which of itself alone will favor the very depression we are seeking to avoid.

They wont, and must see their friends, and bid them good-bye, who through excitement and sympathy will gather around them in spite of the surgeon's advice, and add another factor to increase the already overburdened nervous system.

Whilst we are waiting for nature to react, the pain, hemorrhage and mental excitement are busy at work, reducing the general powers of the economy, which soon must bear a second shock under much less favorable circumstances than the first.

On the other hand, if an early operation is resorted to, you cut short the hemorrhagic oozing so common in many injuries attending railroad and machinery accidents; you relieve the mental strain and irritation, deaden the excruciating pain so prostrating to the general economy, by the use of ether, and at the same time support the heart and establish the depressed circulation, and hasten the separation of the dying mass of mangled flesh from the living, thus removing the prime cause of that which you are seeking to relieve; after which your patient will awaken, in one sense feeling refreshed as it were, and often the first rational word they say will be, "is the operation all over?" to which an affirmative answer alone, from the surgeon, will add a stimulant to the depressed nervous system that bears no comparison with the most flattering promises of a successful operation *before* it is performed.

It cannot be denied that impressions have a decided influence in stimulating or depressing patients under any circumstances, and especially those suffering from severe injuries, and the sooner we can bring cheer and encouragement to our patients, the sooner we will get rid of one depressing factor in their case.

What reasons are there for delay at all, when our best authorities not only admit of, but advise early operations in severe head injuries involving the brain, to save life, and do save it by prompt action, regardless of shock; or where there is marked hemorrhage, or a shattered bone, or a strangulated bowel, or a crushed extremity, which is prolonging the shock, which we all must admit is relieved, if relieved at all, as a rule, by prompt and early operative interference?

If early operations are advisable and have proved successful in these hazardous cases, why are they not advisable, and not only advisable, but

the best practice under milder injuries, or that class of surgical injuries which come in between the two extremes?

For my part I can neither see a theoretical or practical reason for delay at the present day, with ether and nitrite of amyl at our command on the one hand, and antiseptics awaiting our bidding on the other, with the supplemental aid afforded by the hypodermic, when absorption through either the stomach, rectum or skin is so obtunded as to make delay based on their action fatal.

By early operations in surgical injuries I do not mean rash carelessness or indiscriminate operations without regard to the patient's condition or prospects of recovery; but I do mean that the sooner a mangled limb is removed after it has become evident that such is necessary, the better it is for the patient, and that by doing so it will relieve him of unnecessary and prolonged pain, increased hemorrhage, greater mental depression and general shock, and in its place will give comparative comfort, relieve the mental agony, give support to the vital powers, lessen and cut short the shock by hastening reaction, and thereby increase, instead of diminish, the patient's chances for life.

SYNOPSIS OF THE DISCUSSION OF DR. REED'S PAPER.

Dr. A. Dunlap, of Springfield, opened the discussion by saying he only arose to indorse the paper just sent, and thank the author for it. He said he had seen many cases in which early operation was the only means of saving life, and that it, as a rule, was good surgery.

Dr. Weaver, of Dayton, said he was in favor of taking the middle ground, and doubted that either extreme was good surgery. He was in favor of waiting until he had some evidence of reaction setting in; that in his opinion an early operation would serve to increase, rather than diminish the shock. Whilst he thought it might be good surgery to operate early in depressed injuries of the skull, he considered them entirely different from other surgical injuries.

Dr. Hyatt, of Delaware, said he would be governed in operating by the *degree* of shock. That owing to vaso-motor paralysis, the blood is drawn away from the heart, and he would advise waiting until that was sufficiently overcome to at least partially re-establish the circulation. He would favor reaction by the use of internal remedies, and warmth to the surface and the extremities. He did not think it best to operate until

reaction had been established, and he was not in favor of setting aside the experiences and instructions of the old authors.

Dr. Gill, of Cleveland, said he fully indorsed everything in the paper; that he was long since convinced by experience that early operations had saved many that would not and could not have recovered from severe surgical injuries without them. He referred to cases which had repeatedly come under his notice, which had actually rallied from shock by the removal of a mangled limb.

Dr. W. J. Scott, of Cleveland, said he was not much of a surgeon, but in his capacity he was often called to the city hospital to give advice in regard to the necessity for an operation, and that he was satisfied that in the majority of cases an early operation was preferable. He illustrated the necessity of early operations by a number of interesting cases which had come under his care from time to time, in which early operations had been performed with success, and closed by urging the advantages of prompt operative interference as the best, as a rule.

Dr. Hall, of Chillicothe, advised time, especially in all desperate cases in which he was not sure of their recovery, and recommended the use of dry heat to hasten the reaction, but did not think it wise to operate before it was established, as a rule.

Dr. N. Gay, of Columbus, was in favor of early operation, and used ether as a means of diagnosis. If the pulse responded to the use of ether and became stronger, he went on with the operation; but if it did not, or became weaker, or the radial pulse became lost, he did not operate.

Dr. J. W. Hamilton, of Columbus, said he was not in when the paper was read. He was decidedly in favor of early operations in some injuries. In fact, in many instances they would never react, if we waited for reaction to come on first.

Dr. Harman, of Warren, said that he thought chloroform was a stimulant at first to the heart, and that it only became a depressant when it was pushed, and that he thought when ether was pushed to the same degree of anesthesia, it was as much of a depressant as the chloroform. He thought the chloroform stimulated the heart while under shock, and that he would prefer operating with it rather than waiting for reaction to come on first.

The discussion was closed by the author, who referred Dr. Harman to the elaborate experiments on the use of chloroform, bromide of ethyl and ether by Dr. Watson, of Jersey City, N. J., and also those conducted

by Dr. H. C. Wood, of Philadelphia, in both of which it was clearly demonstrated that chloroform and bromide of ethyl were both heart depressants as shown by the sphygmograph, and that ether was a cardiac stimulant. He said he was glad to see the conservatives were coming over; that they were now half way, having taken their position on medium ground; and that he thought we would all soon be of the same mind on this important subject. If it was advisable to operate early in order to save life in severe injuries of the head with depression of the skull, he could not see why it was not, in injuries of less magnitude. That if you waited for reaction to be established in many of these cases, you would wait in vain; for unless prompt relief was given they would never react. In many of these cases, to give time was to wind up the patient's time forever. He said he always observed the rule spoken of by Dr. Gay, and if the pulse did not respond to the use of ether, he did not consider it wise to operate, but if it did, he considered it good surgery, as a rule, to resort to early operation, which he considered was giving the patient the best chance for his life.

AN IMPROVED METHOD OF OPERATING FOR CLEFT PALATE.—A correspondent writes to *The Lancet* concerning what he considers a great improvement in the operation for cleft palate. Hitherto great difficulty and not a little danger have arisen from hemorrhage during the operation, necessitating frequent and very skillful assistance, periodical discontinuation of the anesthetic, and distinct intervals in the performance of the operation. In addition to these, other and minor troubles are experienced. All these difficulties may be avoided, and the operation rendered perfectly safe and easy, by the simple process of inversion as applied to the head only. This can easily be attained by bringing the patient's shoulders well up to the end of the operating table, and allowing the head to hang over the edge in the fully extended position. In this position the roof of the mouth would be horizontal or slightly inclined downward towards the operator, who should stand at the head of his patient. The anesthetic is given through the nose by a small tube, and is quite out of the way of the surgeon. Only one assistant is required, who should stand to the left of the operator. In paring the edges no change of hands is required, but the corresponding hand should be used in elevating the tissues of the hard palate and in passing the sutures. Under these circumstances no blood can enter the larynx or esophagus, the palate remains unobscured by blood, and whatever hemorrhage occurs finds its way into the nasal cavities, and at the conclusion of the operation may be emptied by simply turning the patient's head to one side.—*Med. Record.*

**THE IMPORTANCE OF AN EARLY DIAGNOSIS IN
GLAUCOMA.**

BY J. W. WRIGHT, M. D., COLUMBUS, O.

A paper read before the Ohio State Medical Society, June, 1886.

It is not necessary for me to offer an apology for this paper, when it is understood how little is known of glaucoma by the general practitioner.

This is readily accounted for, if we take into consideration that works upon general medicine and surgery are almost silent, or at most, do not treat the subject as pronouncedly as it demands. Hence this communication is directed to the practitioner of medicine, whose attention is called to the importance of an early diagnosis of a disease which has so insidiously caused so much blindness.

I believe there is no one thing that would augment the humanity of the physician so much as to make a searching study of glaucoma, sufficiently *at least* that he may be able to warn his patient of the impending danger, and point him, if nothing more, to a road of safety.

I made the assertion a year ago, in a paper read before the Alumni association of Cincinnati College of Medicine and Surgery, February 26, 1885, that I believed there were a thousand people in the State of Ohio blind from this affection; to day I am better prepared to repeat the affirmation and increase it with an additional fifty per cent.

Now, if this is a fact—and I feel that I have not overestimated it—it is really alarming, and at the same time it is very humiliating when we reflect that at least ninety per cent. of this number could have had, with proper treatment, tolerable vision to day, besides having been relieved of much unnecessary suffering.

Whether there is an increase of this disease in a greater ratio than the natural increase in the population cannot be ascertained, for it has only been a few years since its pathological condition has been determined. Certain it is that it existed, and the vast number of eyes that were rendered sightless was attributed to the general, and at the same time vague cause, *amaurosis*.

It is not the object of this paper to enter into a detail of the etiology and pathology of glaucoma, but to take a cursory view of its symptomatology in contradistinction with some other diseases which it occasionally simulates, and which are likely to deceive the practitioner who rarely meets such cases. We will therefore endeavor to point out the most im-

portant symptoms, and give the distinguishing characteristics of this affection as compared with some other affections, so that the observer may more readily recognize this disease.

There are two affections with which this disease may, by the casual observer, be confounded, viz: Neuralgia and senile cataract.

Acute glaucoma may be, and often is, mistaken for neuralgia—the pain in and around the eye simulating that affection.

The periodicity of subacute glaucoma, in which there is entire freedom from pain, whilst this is one of the landmarks in its diagnosis, is also diagnostic of neuralgia.

In order that we shall have a methodical arrangement of the subject, we will make a division of the symptoms into the *objective* and *subjective*.

OBJECTIVE SYMPTOMS.

The old are most subject to glaucoma, and it is more frequent among women than men.

There is *increase of tension*; that is, increased hardness of the eyeball.

In the early stages there is apparently no increase of tension; as the disease advances, however, there is increased tension, sometimes not very marked—in other cases the eye is of a stony hardness.

There is diminished depth of the anterior chamber, and the iris and lens are pushed forward toward the cornea, in advanced cases almost touching it.

The cornea often appears semi-translucent, having lost its brightness. There is dilatation with sluggishness of the pupil, that is, *the pupil does not respond actively to the light*.

In the case of neuralgia there is contraction of the pupil. In cataract there is dilatation of the pupil, *but when uncomplicated the pupil responds readily*.

(The cupping of the optic papilla, together with the pulsation of the arteries of the same, one of the most important symptoms in glaucoma, can only be detected with the ophthalmoscope; hence its mention here is unimportant only to those familiar with its use.)

In acute glaucoma the attack is usually at night. The pain in acute glaucoma is violent, radiating from the eye through the head. There is also considerable conjunctival irritation.

The first and most important symptom in subacute glaucoma is with intermissions of entire freedom. With each

loss of vision, which is never recovered. The paroxysms are more severe at night.

In hemicrania or megrim, on the other hand, the pain is more violent during the day.

The intermissions may be a few days or it may be weeks, or months, or as long as a year.

We will find on inquiry that the patient has had considerable uneasiness, and frequently much pain of a neuralgic character about the supra-orbital and temporal regions and along the side of the nose.

In chronic glaucoma there is a gradual loss of vision, but as a rule it is not accompanied by pain—although when the patient is questioned, it is frequently ascertained that there has been a sense of “uneasiness” about the eyes.

Where the increase of tension is so slow, there seems to be a gradual adaptation to the condition; hence the absence of pain.

It is in the chronic form that so many are deceived, the sight being so gradually lost that it is often mistaken for the formation of cataract.

A very important symptom in any form of glaucoma is the appearance of the colored halo around the flame of a lamp or candle.

For the purpose of impressing the importance of this subject, I will submit a few cases which came into my practice during the past year.

April 28, 1885, I was consulted by Mrs. L., aged 53 years, of Shanesville, O., with the following history:

About five years ago she commenced suffering from severe pain in the left eye. It continued more or less severe for about four years, during which time it gradually lost its sight, until about a year since when she became blind in that eye—she not having the least perception of light with it.

About two years after the first eye became affected, she began suffering from pain in the other one, although not so severely as in the first eye; yet she had gradually been losing the sight in it, until the time I made the examination, when she could scarcely distinguish between persons even when near her. She could not read, nor had she for a year. She had consulted a prominent physician and was told by him that she was going blind from cataract, and she must be patient until they were “ripe,” and when she became blind she could be operated upon.

I was called to ascertain if one eye at least was not in condition for the operation. She was very much surprised when I informed her that it was not. For me to tell her this, with the eye already blind, and the

very best that could be done with the other would enable her only to retain what vision she had at that time.

Accordingly with that in view I at once, assisted by Dr. A. T. Miller, made an iridectomy in both eyes, not that I expected to benefit the left one in restoring any vision, but she suffered some pain at times in that eye, and to avoid a sympathetic effect from it, on the other eye, it too was operated upon.

From the time the operation was made all neuralgic symptoms subsided, and after a week, when the bandages were removed, there was a gradual improvement in the sight of the eye, until now she is able to distinguish persons when near her. She says her sight is getting better all the time, but it is probable there will be no further improvement.

In this case the left eye was of almost a stony hardness, the lens was opaque and pushed forward with the iris, and almost touching the cornea. In the left eye an examination with the ophthalmoscope revealed the cupped papilla. The halo around the light of a lamp was visible to her, and was noted with the other eye before it became blind.

July 29, 1885, I was consulted by Mrs. S., of Navarre, O. She is 60 years of age. For the past three years she has been suffering from severe pain in and over the eyes and in the temporal regions. At times the pain has been excruciating, then again almost subsiding, but not entirely.

The last three months the pain has been unusually severe. An examination revealed increased tension. Ophthalmoscopically the cupped disk was noted, and also a diminution of the retinal vessels. She described the halo around the light of a lamp.

With the assistance of Dr. Allinder I made an iridectomy in both eyes. She was relieved at once of the pain in the head, and slept better the second night after the operation than she had done for months. She has continued improving in health and vision, and has been relieved of terrible suffering and imminent blindness.

This lady had been treated for two years by a reputable physician for "granular lids" and "neuralgia."

November 19, 1885, I was called to see Mrs. M., of Lore City, O., in consultation with Drs. Wall of Cambridge, and Lowry, her attending physician. We found her suffering excruciating pain in the left eye, with occasional pain in the right. The sight in the right eye was lost about two weeks previous to this time, and was very much diminished in the left. Tension was very much increased in both eyes. The pupils were

large and sluggish. The history of the case, as I could gather it, was something like this :

About four months previous to the above date she was taken with what she thought was neuralgia, as she had suffered with this affection during intervals for some years. She was tolerably free from pain during the day, but suffered much at night. As her residence was in a malarious district her physician thinking this was the cause, and not having been able with the usual remedies to alleviate her suffering, advised her to remove to her former home, away from the malarial influences, hoping the change would benefit her. She was here treated by her present physician, who gave her constitutional treatment, but the pain continued. Finally a more severe paroxysm than any previous came on, and with it the loss of the right eye. Following this there was a mitigation of the pain, and for a while it was not so severe. Then came another paroxysm similar to the former, affecting principally the left eye.

At this time the attending physician anticipating the disease was glaucoma, called Dr. Wall in counsel, who confirmed his opinion and advised immediate action.

I was telegraphed and arrived there at dark and finding the case as herein related, proceeded at once to make an iridectomy on both eyes by lamp light.

Although she had been suffering severely at nights for a long time, she rested tolerably well that night, complaining occasionally of sharp shooting pains. They gradually decreased in severity and came farther apart, and finally in three days after the operation disappeared altogether.

We prescribed iron, quinia and strychnia, and she improved rapidly in health until at present she is well. Her vision is entirely lost in the right eye, and is very poor in the left, but sufficient to enable her to get around and attend her household duties. She cannot see to read, but is full of gratitude for what vision she has remaining.

December 24, 1885, was consulted by Mr. R., of Beech City, O. The history of the case is this: His age is 67 years. About two years ago he commenced losing sight in the left eye. There was pain—although not much—more a sense of uneasiness than pain.

About six months previous to the above date he commenced to lose sight in the right eye, at which time he consulted a physician who told him he was going blind from cataract.

Making an examination ophthalmoscopically I found no opacity of the lens, but considerable cupping of the optic disk in the left eye. There

was complete loss of vision in the right eye, with the exception of a mere perception of light on the nasal side. There was slight cupping of the optic disk in the right eye, with considerable contraction of the visual field. Tension in either eye was very slightly increased.

January 11, 1886, with the assistance of Drs. Crise and Robinette I made an iridectomy on both eyes. The patient suffered considerable pain after the operation, until three o'clock the next morning; after this he suffered very little and made a speedy recovery. Vision in the right eye has improved and he is able to get around very conveniently.

April 21, 1886, I was consulted by Miss R., aged 50 years, of Coshocton, O. For the past two years she had been suffering considerable pain, at times, about the temples and supra-orbital regions. The pain was always more severe at night. About two months previous to the time I was consulted, after a severe paroxysm of pain, she ascertained that the sight in the left eye was almost entirely lost. With it she had perception of light, and that is about all. She can tell when an object passes between her and the light with the eye, but cannot distinguish the form or color. Vision in the right eye is very much diminished. She is not able to read, and has not done so for some months. She was told by a physician that she was going blind from a cataract, and advised to have an operation performed. With this in view she consulted me. I found the eyes very hard, the pupils large and responded very sluggishly. The anterior chambers were very much diminished in size, the iris being crowded forward and almost in contact with the cornea, in each eye. The lens in the left eye presented the characteristic green color in a high degree, thus preventing an ophthalmoscopic examination of the retina. There was considerable contraction of the visual field in the right eye, but the ophthalmoscope did not reveal any abnormality, such as cupping of the optic disk, or contraction of the retinal vessels. She noted the halo around the light of a lamp.

April 28th, one week since I first saw the case, with the assistance of Drs. J. G. and E. C. Carr, I made an iridectomy in both eyes. She stated that during the week since I first examined her eyes she had suffered considerable pain, and that the loss of vision was very perceptible.

The patient has now fully recovered. She does not suffer the slightest pain in either eye. Vision has improved some in the right eye, and is as good now, perhaps, as it will ever be.

April 28, 1886, (the same day upon which I operated on the preceding case) I was consulted by Mrs. M., aged 54 years, of Coshocton, O. She began suffering pain nine years ago from what she thought was neuralgia. The pain has never been very severe, and hence did not associate her failing sight with the pain. The dimness of vision she attributed to age and changed glasses frequently.

Vision in the right eye was practically gone, she having merely a perception of light from a point on the nasal side. The pupil was widely dilated and did not respond, in the least, to light. The lens presented the greenish appearance, and was so opaque that a retinal examination was impossible.

The vision in the left eye was very much reduced, and she complained that everything appeared misty. She had noted the colored rings around the light of the lamp. With the assistance of Dr. E. C. Carr an iridectomy was at once made on both eyes.

May 12th I learned from Dr. Carr that the patient was able to be about, and that all pain and the inflammation consequent upon the operation, had subsided. She expressed the opinion that she can now see better than she had done for some time previous to the operation.

April 25, 1886, I was consulted by Mr. R., aged 70 years, of Newark, O. He was so positive that he was blind from cataract that he had sent for me to operate upon his eyes. How he got the impression that he was blind from cataract I am unable to say, as I did not learn from him that he had ever consulted a physician in reference to his eyes.

I invited Drs. Speer and Priest, of Newark, to see the case with me and assist in the operation. I had not seen the case before. Upon entering the room I was immediately impressed, from the peculiar greenish appearance of the lens, that we did not have a case of cataract to deal with. He had not the least perception of light. The eyes were very hard. The scleral vessels were large and tortuous and terminated abruptly. The pupils were widely dilated, and the iris and lens pushed forward toward the cornea.

Not having the time to get a history of the case, Dr. A. T. Speer elicited, for me, in substance the following: He commenced losing sight about four years ago, in both eyes at first, apparently alike; later the left failed the faster, until it gradually became blind. About two months ago he became blind in the other eye. He has never complained of the least pain, or even a sense of uneasiness about either eye. He is quite positive that he has had no pain about the temples or supra-orbital re-

gions, and in fact has suffered in no way, except the inconvenience attending the loss of vision. He noticed the halo around the light of a lamp or candle, and had frequently remarked to his family of the beautiful colored rings.

The lens in either eye was so opaque that I did not attempt an ophthalmoscopic examination.

So many of these cases coming under my observation in such a brief space of time has had the effect of impressing very strongly upon my mind the necessity of a greater publicity of what is already known upon this important subject.

With such a history of cases the subject becomes a *serious* matter of study, especially to the general practitioner into whose hands almost all such cases at first fall, and who certainly has a grave responsibility, especially if the patient is allowed to become blind under his own eyes, whilst a means of cure is generally within his own hands—if he is only cognizant of what *is* and should be more *generally* known upon this subject.

117 EAST SPRING STREET.

IMPACTED COLON.—Prof. Da Costa directed in a case of *impacted colon* of one week's duration, that an injection should be used, of turpentine $\frac{3}{4}$ ss, beat up with the white of an egg and mixed with a pint of hot water, to be followed by simple hot water and salt. In case this treatment failed, warm sweet oil was to be used. Internally was given: R.—Magnesii sulph., $\mathfrak{g}$ j; acid. sulphurici dil., gtt.ij; elixir simplic., aquæ. aa f $\frac{3}{4}$ ss. M. Sig.—To be given every half hour.

At the next clinic the patient returned well, the cure having been accomplished by the injections of sweet oil and a pill of aloes, belladonna and colocynth, on the third day of the treatment.—*Coll. and Clin. Record.*

A SARCOMATOUS TUMOR MADE TO DISAPPEAR BY AN ATTACK OF ERYSIPELAS.—A girl, aged eight, had a sarcoma larger than a hen's egg, involving the left tonsil and nearly the whole posterior half of the buccal cavity. Tracheotomy had to be performed. The patient then caught erysipelas from another patient, the disease lasting six days. At the end of this time the tumor was reduced to two nodules, the size of a pea, which were excised. Two months later, the disease had not returned.

TRICHINOSIS IN BERLIN.—Dr. Grawitz, who gives the course in pathological histology for Virchow, says that about one-third of the cases diagnosed in life as muscular rheumatism are shown, by post-mortem examination, to be trichinosis.—*Medical Press of Western New York.*

DIETETICS IN IDIOPATHIC FEVERS.

BY PROF. H. J. HERRICK, M. D. CLEVELAND, O.

A paper read before the Ohio State Medical Society, June, 1886.

We meet in our daily practice fevers, which have been styled "essential fevers," and have been variously named from prominent symptoms or supposed organic affections, intermittent, remittent, bilious, gastric, catarrhal, typhoid or enteric.

They are, or may be spoken of as, idiopathic fevers in distinction from the special fevers following traumatic inflammations.

It is to be noted that these forms of fever are treated of by different authors without defining very definitely their source, or the organic lesion present; they are treated of as having an "essentiality" independent of any lesion. They are spoken of as having a kind of entity in themselves, and therapeutic measures are resorted to, which, experimentally, are thought to abate the *fever* without reference to its cause. I wish to renew an old controversy, though my purpose is not to discuss the nature of fever, and maintain that all fevers as such are symptomatic, and should be treated as such.

The only obscurity is in associating the fever with the particular organ or group of organs suffering.

It is noticeable that the organs suffering in these obscure forms of disease are located in the abdomen, and not so isolated as other organs in the cranial and thoracic cavities.

If an organ of either of these cavities is affected by inflammation, we use a term indicative of the organ affected, as cerebritis, pneumonitis, carditis, but if one of the organs of the abdomen is affected we leave our method of associating the symptoms and fever with the organ suffering, and introduce new and arbitrary terms that have their origin in a leading symptom, or group of symptoms. By this method we often find ourselves treating only the symptoms of a disease, or a name of a disease, irrespective of the condition of the organ suffering. I have often thought that we, as physicians, are prone to lose sight of our anatomy and physiology when we come to the question of therapeutics.

All will accept the statement, that if every organ of the human organism performs its function perfectly, the person is in health, or if an organ or group of organs fails to perform its function, disease is the result.

Disease is not an entity, but a term indicating impaired organic function. Surely then the more accurately we analyze the function of the various organs, and determine their normal and abnormal conditions, the more expert we become in detecting the various phases of disease, and the more skillful in devising means for correcting the deranged condition.

To my mind this is the natural mode of investigating disease. Nature our guide, knowing her methods, when there is a departure from them we are able to analyze our armamentarium and determine if from it we can bring anything to her relief.

This to me is rational medicine. Treating disease by its name disconnected from the organ of suffering, is empiricism, and he who practices medicine in that manner is a charlatan. Of such there may be found some even in the *regular* profession.

I wish to present some points which appear to me to have been neglected in the treatment of fevers due to inflammation of organs in the abdominal cavity. To a certain extent, with certain modification, all idiopathic fevers are included in the line of our thought.

I wish to direct attention to the dietetics in those fevers. It may be noted that food is not improperly included under the term therapeutics. Indeed, often during a diseased condition, a judicious selection of food may be all the therapeutics required, and having been supplied with that in the form and amount required, the very best remedial agents possible may have been supplied, or if food is given in such a form or in such an amount as not to be fully utilized and disposed of, we have administered a veritable poison.

I am certain that I have seen patients suffering from fevers arising from diseases of the bowels and liver furnished with fatal poison which was designed as supporting food. It is to be admitted that one of the important indications in treating this class of disease is to support the patient. With equal emphasis, I may say that another equally important indication is, "if an organ is inflamed, rest it."

In the disease of the organs under consideration, the very organs are affected that are essential to the digestion, transformation and absorption of food. In this lies our difficulty; in considering this matter of support it must be borne in mind that nature usually has provided the necessary support in such emergencies by supplying the person in health with an excess of that required by the wear and tear of the body; as such it is deposited as fat throughout the various parts. This is one of the many conservative provisions in a beneficent arrangement.

For the use of this reserve food all that is required is water, and for this supply a greatly intensified thirst is given. It is not an appetite for food, but a thirst for water. If food is offered it is loathed, yet if food is administered as drink under the stimulus of thirst, it may still require digestion—a process which cannot be accomplished under the diseased condition of the digestive organs.

Then our patient "has asked bread and we have given him a stone." It has become a firm conviction with me that our daily habit of taking food, both as regards amount and quality, is among the most fruitful causes of disease, and that far too little attention is given to the matter of food in health as in disease.

We somehow get the impression that whatever articles of food are put into our stomachs represent so much strength, whereas it may be a positive source of weakness and disease.

If digestion, absorption and assimilation do not take place in their order, fermentation or putrefaction is sure to follow, when we have various *materies morbi* at the very door of entrance into the circulation.

If the bacteriologist insists upon the specific germ as an essential factor you have the conditions most favorable for its propagation. Nature is bountiful with her germs. Wherever the favorable soil is present, there she furnishes the germ for revivifying the protoplasmic mass to arrest it from corruption and decay.

But my purpose at present is to call attention to the question of food in certain diseases of the digestive organs, more especially in bilious and typhoid fevers.

In typhoid we recognize medication as involving the minor part of the duties of the physician, the attention to the air, bathing, change of clothing, drinks and nutriment involving the larger share of attention.

No one of these duties is more important to the welfare of the patient than the means used to repair the rapid waste.

What form of food can be given that shall be appropriated by the patient, considering the arrest and impairment of secretions, and that shall not act as an irritant to the thickened, inflamed or ulcerated glands of the ileum?

I think all will agree that during the active febrile inflammatory stage of the disease there is no diarrhea, but rather constipation. Then the secretions are checked; any article of food, as milk or gruels, becomes solid, and *often* is undigested and becomes impacted above those inflamed glands, adding seriously to the aggravation of the diseased condition

already existing, disposing to increase of fever, septicemia, ulceration and perforation.

These results are not imaginary, for I am certain that I have often seen them fully illustrated in cases. We are often misled by authors who presume to lay down *guiding principles* for our use.

Dr. Hutchinson, the learned author of the article on Typhoid Fever in "Pepper's System of Medicine," interdicts solid foods very properly; but he fails to remember that many of the fluid foods under the condition of fever soon become solid in the digestive tract by the absorption of the fluid portion, or that the coagulation of milk in the first step to digestion gives a hard curd which becomes most indigestible, hence an actual irritant; or if the milk is digested, the residuum is the most solid of that of all other foods and forms the hardest fecal accumulation. He advises milk to the amount of one or two quarts daily. This custom I know is practised by reputable physicians who crowd milk to the fullest possible extent. Now the patient is thirsty, he wants drink, not food. If food were given it would be declined at once, but the cooling draught of milk satisfies a craving thirst but at the same time adds an irritant to the diseased digestive organs. He asks for water and you have given him food. But the learned author above referred to adds further advice which I am sure is followed by many, both in this disease as also in diarrhea of infants, which advice I am not able to approve. He says "if the milk curdles and does not digest give lime water mixed with the milk." Now lime water may seem to be so simple as to be prescribed without a thought, but is it not a caustic irritant in full strength? Does it not act to arrest the very first step in digestion? The caseine of the milk is an albumenoid and requires the action of the gastric juice for its digestion; here we give an alkali that arrests this first transformation.

In this does our practice conform to well recognized physiological teachings? This question may seem of small moment, but let me state my own convictions after a large experience, that success in the treatment of our patients turns upon the careful attention given to the smallest details in our art. It is the fine touchings that mark the skillful artist. The physician in his ambition to do some great thing neglects much of the little detail on which his success depends.

Whatever class of nutriments we select, we must keep in mind the facts that food to be of value must be absorbed; to be absorbed it must be digested; to be digested, there must be the presence of certain secretions along the course of the digestive tract. A further fact must be kept in mind,

in the treatment of fever from any source and especially where the digestive organs are involved, that during the fever, the secretions are checked or perverted; the tongue is dry, the skin is dry and hot, the urine is scanty, bowels are constipated.

A further fact should also be kept in mind, that where the vital changes within the body are arrested or impaired, putrefactive changes are likely to follow, adding an irritant to the already affected glands of the bowels, or the putrefying fermented material may be absorbed, enter the circulation and affect organs near or remote; adding to the already exhaustive labors of the vital forces.

These statements appear to be so self evident as to need no further comment. What are the means then for supporting our patient? Let us follow the clear leading of nature in answering the question. She has usually, as I have already indicated, provided for certain emergencies of this character in the deposits of fat. All that is necessary to utilize this supply is to furnish water, which is the great medium of all vital changes, and this the patient craves.

Let the suffering organs rest, but give to the fullest desire fresh, pure soft water. It insinuates itself among the tissues, favors in them those metabolic changes which constitute the phenomena of life.

But you say, would you give no food? Not during the active febrile stage. Mild acidulated drinks, cooked fruits, or mucilaginous drinks are all I would allow.

Whenever the fever abates, or when the powers of the patient are flagging from the exhaustion of the reserve, I would give the meat juices or broths such as may be absorbed without digestion, leaving little or no residuum to clog or irritate the diseased bowels.

It is my custom to prescribe definitely the food and drink my patient is to have, as well as the medicines administered.

If food is given, it should be in that form which is the nearest approach to the tissues of the body, in which the least digestive power is required. The clear meat broths or the expressed meat juices meet the indications most perfectly of all substances.

When we consider the appropriate forms of food and support in bilious or remittent fever, certain modification of our conclusions is necessary, and this is from the location of the lesion causing the fever.

The liver being the suffering organ—under the guidance of that principle which requires to rest the organ suffering inflammation, we must keep in mind the functions of that organ, both as a gland secreting bile,

and as an organ with a glycogenic function for the transformation of sugar and starch into glucose, and a further elaboration of fat.

A failure to heed these functions and their impairment in diseases of the liver is liable to result in allowing the patient to take those articles of food that shall aggravate the diseased process.

It is not difficult to perceive that a rigid care in the dietetics alone of bilious fever may be sufficient to effect the cure.

In diseases of the liver, especially the inflammatory with fever, I am in the habit of withholding carbo-hydrates scrupulously, but prescribing water freely and that hot or as warm as the patient can bear it. Should there be nausea, I combine bicarb. of soda in small quantities often repeated until thirst is satisfied and fever abates. I am quite certain that many of the serious complications which arise in the treatment of those forms of disease are due to errors in feeding. Under the urgency of friends and our own anxiety to keep up the strength of the patient, we allow ourselves to forget these common-sense precautions in our treatment. Few or no patients die from exhaustion, but rather from certain organic affections resulting from the diseased process which are liable to have been aggravated by the thoughtless, irrational efforts to keep up the strength.

If I shall have succeeded in enlisting thought in this matter, it is all I hope to have accomplished, and trust your statements will show the fallacy of my reasoning, if such there be. Truth is our aim. Let it be applied to practice.

MEDICINE.

ON THE DIAGNOSIS OF SMALL-POX. (P. A. MORROW, M. D., OF NEW YORK.) While it is important, in the interests of the public health, that small pox should be promptly recognized and the patient isolated, it is equally important, both in the interest of the patient and for the credit of the physician, that a mistake should not be made in the opposite direction and the patient sent to the hospital and exposed to the almost certainty of contagion from contact with small-pox patients. The laity are little tolerant of such mistakes and usually attribute them to ignorance, carelessness, or undue haste on the part of the physician.

Practically, however, we find that such mistakes are often made, even by the most careful and experienced physicians. The records of all small-pox hospitals are prolific in statistics of this nature. Marsden says: "Upwards of twenty diseases have been mistaken within the past few years, in the early stage of the illness, for small-pox and *q. v.* patients have been sent, as having small-pox, to the London Small-pox Hospital."

Neumann reports that thirty-five patients with measles, scarlatina, erythema, etc., were erroneously admitted as having small-pox. Into the Small-pox Hospital of this City, from 1880-1885 inclusive, over 2,500 cases of small-pox were admitted. Thirty-one cases wrongly diagnosed as small-pox are classified as follows: Typhus, 13; measles, 9; syphilis, 3; acute eczema, 1; varicella, 1; psoriasis, 1; acne, 1, purpura hemorrhagica, 1; malaria, 1. On the other hand, eleven cases of small-pox wrongly diagnosed are thus classified: Typhus, 8, typhoid, 1; scarlet fever, 1; measles, 1. A total of 42 instances of mistakes as regards small-pox. In addition to these there was a much larger number of wrongly diagnosed cases which were received at the Reception Hospital in East 16th street and not transferred to the Island Hospital.

An examination of the record of the "Reports of Contagious Diseases submitted to the Board of Health of this City for the past twelve weeks ending January 16" discloses the fact that seventy-two cases of small-pox had come under the observation of the Health Board within this period. In addition to these cases of undoubted small-pox, thirty-eight cases were reported as such, which, upon investigation, were found not to be small-pox. An analysis of these 38 cases shows that the diseases mistaken for small-pox were represented as follows: Varicella, 17; syphilis, 5; measles, 3; lichen tropicus, 1; lichen, 4; vaccinia, 1; herpes, 1; pemphigus, 1; miliary fever, 1; sudamina, 1; erythema, 1; urti-

caria, 1. I have included in this list only such cases as were reported in the name of the attending physician. The large number of mistakes in diagnosis disclosed by this exhibit, it may be remarked, is the more significant considering the comparatively few cases of small-pox in the city. In the presence of an epidemic outbreak of the disease, when physicians are more keenly alive to the possible variolous nature of every doubtful eruptive disease, it may be reasonably inferred that a proportionately large number of mistakes would occur. Incidentally it may be mentioned that at least two of the mistakes were made by physicians who presumably possess more than ordinary skill in the diagnosis of eruptive diseases, as both have been prominently identified with the teaching of skin diseases in medical colleges in this city.

These facts are not brought forward as an arraignment of the medical profession for carelessness or incompetency; they are not to be interpreted as an impeachment of the clinical judgment or diagnostic skill of the physicians making the reports. They simply illustrate the fact that in a certain proportion of cases of eruptive disease it is often impossible for the physicians to pronounce positively upon the nature of the disease within the first twenty-four hours. However strongly the clinical signs may point in favor of the variolous character of the eruptive accidents, there are so many sources of error possible that the physician should suspend judgment until time clears up the diagnosis.

As before intimated, no other disease is characterized by more distinctive symptoms or is more readily recognized than a typical case of small-pox. The series of changes which the eruption undergoes in its development and decline are too familiar to be here described. They may be briefly referred to, however, in order to bring into relief the deviations from the ordinary evolution of the disease. Small-pox ordinarily begins with a chill, succeeded by a fever with headache, severe lumbar pains, nausea, sometimes vomiting, and other signs of constitutional disturbance. These symptoms subside with the appearance of a rash on the third day, in the shape of small distinct papules, hard and shotty to the feel, first appearing on the forehead, face, and back of wrists, successively invading the neck, trunk, arms, and lower extremities. On the fifth day, the papules are converted into vesicles which become depressed in the centre and surrounded by an areola. On the eighth or ninth day, the vesicles are transformed into pustules which, after the eleventh day, burst, discharge their contents and form scabs, which fall off, leaving pigmented cicatrices, the entire process being completed in

from seventeen to twenty days. This series of symptoms and the regular order of their succession make up a clinical picture which is imitated by no other disease. While many of the symptoms are common to other eruptive fevers, yet the acute lumbar pain and the subsidence of the fever upon the appearance of the eruption are pathognomonic small-pox. The same may be said of the eruptive features. The anatomical form of the lesions is not peculiar to small-pox, yet the pock occurs in other diseases rather as an accidental formation than a typical lesion; its mode and rate of development are altogether different.

The diagnosis of small-pox is usually difficult in proportion to the duration of the attack. In the early stage, when the premonitory symptoms are doubtful and the character of the eruptive accidents uncertain, the simple element of time resolves all doubt. A papular eruption, for example, which remains unchanged longer than two days, does not indicate small-pox, since the transitional stage of the small-pox papule does not surpass that period. However important the chronological element may be as a differential factor, practically we cannot always apply the test of time, since we are compelled to report an opinion within twenty-four hours after first seeing the patient, and this enforced precipitancy in making a diagnosis is the explanation of many mistakes which would not be possible at a later period, when the disease is more advanced in its evolution.

In the early eruptive stage, the premonitory symptoms, especially when conjoined with a history of known exposure, are much more important from a diagnostic point of view than the eruption itself. The initial exanthem, especially when hemorrhagic, is, of course, pathognomonic, but it occurs with such a varying degree of frequency in different epidemics that its inconstancy deprives it of value as a diagnostic element.

It is, however, the modified forms of small-pox, and the cases characterized by the production of macular, measly and hemorrhagic rashes, that occasion the most difficulties of diagnosis. Undoubtedly the chief element of confusion has been introduced by the practice of vaccination. Vaccination *denaturalizes* small-pox: it deranges the regular order of its evolution and effaces its most distinctive features. This modification varies in degree in different individuals, according to the efficiency of the vaccination and the proximity of its performance.

Variloid may have nothing constant, nothing definite, either in its constitutional accidents, the character of the eruption, or the duration of the morbid process. The premonitories may be as severe and protracted

as in true variola, or they may be slight and of but a single day's duration. The eruption, instead of beginning upon the face, may make its first appearance upon the chest, back, or extremities, it may be sparsely scattered or thickly disseminated. Some of the lesions may abort at the papular stage or the vesicle may represent the acme of development. There may thus be present at the same time abortive papules, dried up vesicles, and advanced pustules. Umbilicated vesicles which constitute the specific sign of small-pox may be entirely wanting. Desiccation may begin as early as the fifth day. It is very rare indeed that the eruption passes through the entire cycle of evolution typified by the true variolous process.

Notwithstanding the benign character of varioloid, it possesses the same contagious activity as true variola, and, from a prophylactic point of view, its early recognition and the prompt isolation of the patient is quite as important. A case of peripatetic varioloid may be a more efficient agent in spreading the contagion than a case of confluent small-pox.

Measles.—Passing now to the consideration of the differential diagnosis of the diseases most commonly mistaken for small-pox, it may be said that, in point of frequency, measles occupies the front rank. While the period of invasion is a little longer in measles, the initial eruption of some forms of small-pox is oftentimes indistinguishable from that of measles, especially when of the papular variety, and it does not appear so surprising that these diseases were so long regarded as identical.

In measles there is often a coincident development of the eruption upon the back and face, while in small-pox it first appears upon the face. The papules of measles are larger, softer, and of a more vivid hue, contrasting with the pale color and hard shotty character of the small-pox papules. The former give to the hand passed over the surface a smooth velvety feel, while the latter communicate a rough, hard sensation. It is, of course, only at the onset of the eruption that such a confusion is possible; in the course of twenty-four to thirty-six hours the papules of measles become more macular, while the papules of small-pox manifest evidences of a vesicular transformation. Independent of the eruption, the most important differential signs are the absence of lumbar pain during the period of invasion of measles, the maximal development of temperature during the height of the eruption, and the coryza, lachrymation, and other mucous membrane symptoms peculiar to this disease.

Measles may also be confounded with a form of hemorrhagic small-pox, in which the measly eruption is succeeded by petechiæ which may

constitute the only cutaneous expression of the disease, and the patient often dies of hemorrhagic small-pox without a trace of a vesicle being present or before any unequivocal signs of small-pox are manifest.

Varicella.—In the record of thirty-eight cases wrongly reported to the Board of Health as small-pox, there were seventeen cases of varicella. This relatively large proportion may be explained by the fact of the unusual prevalence of varicella in this city at the present time. A small contingent may have been reported by physicians who believe in the substantial identity of the two diseases—an opinion which was formerly generally held, and is still entertained by some authorities. Considering the close resemblance of varicella to modified variola in the mode of its development and the anatomical form of its lesions, it is not surprising that the two diseases should sometimes be confounded. This resemblance is rendered more striking in the exceptional cases in which varicella is attended with a high degree of constitutional disturbance, with distinctly umbilicated vesicles which are followed by sloughing of the skin and permanent cicatrices. Ordinarily, however, there is slight systemic disturbance or none at all. The rise of temperature follows, rather than precedes the eruption which is often the first symptom that marks the disease. The eruption is most characteristically developed on the back, but may be distributed over the entire body. The vesicles are superficial; they rise from a hyperemic spot, rapidly mature, and attain their maximum development in one or two days; they are soft, globular in shape, rarely umbilicated, and unicellular in structure; their contents may be evacuated by a single puncture. The individual lesions pass through their successive changes in from five to ten days. An important differential feature is that the eruption comes out in successive crops, so that we may have the eruption in different stages of development at the same time. Another diagnostic feature is that varicella is essentially a disease of childhood; some authorities maintaining that the occurrence of a varicella-like eruption in an adult would necessarily exclude the diagnosis of chicken-pox. Clinical experience would seem to prove, however, the susceptibility of adults, though, in the slightest degree, to varicella.

Scarlatina.—The resemblance of the prodromic rash of small-pox to scarlatina is sometimes most striking. The absence of sore throat and the typical tongue of scarlatina, taken in conjunction with the symptoms of invasion, are important diagnostic points. The appearance of a papular eruption on the third day would resolve all doubt. In hemorrhagic

small-pox the intense congestion and the dark-red color which sometimes precedes the hemorrhagic exanthem may simulate a scarlatinal eruption.

Typhus Fever.—In the statistics of the Small-Pox Hospital it will be remembered that thirteen cases of typhus fever were diagnosed as small-pox, and eight cases of small-pox were mistaken for typhus. It is, of course, only in one of the hemorrhagic forms of small-pox that such a mistake is liable to occur. The purpuric eruption of small-pox occurs at an early period, and the patient rarely lives to the seventh day, at which time the eruption of typhus appears. In variola hemorrhagica, the purpuric spots are larger and are attended with hemorrhages from the mucous membranes and hemorrhages into the conjunctivæ. In typhus fever, there is active delirium and other mental disturbances, while in hemorrhagic small-pox the mind is perfectly clear. The exanthem of spotted fever (cerebro-spinal meningitis) may also be mistaken for the petechial eruption of small-pox.

Purpura Hemorrhagica, as well as the cutaneous hemorrhages of purpura simplex and peliosis rheumatica, have been mistaken for petechial small-pox. In purpura, the eruption first develops upon the lower extremities, and rarely extends to the trunk and upper extremities. The history of the invasion, the sudden advent of the eruption, and the absence of subjective symptoms are important differential points.

Syphilis.—The similitude of syphilis to variola, it may be inferred, was recognized by the old authorities in giving the latter the name of "small"-pox, and the term variola-form syphilide, which is still employed by modern writers on venereal, would indicate the identity of certain forms of dermato-syphilis with the characteristic lesions of small-pox. There is not only identity of anatomical form, but also of development through the stages of papule, vesicle and pustule. The similitude is heightened by the fact that in some rare cases syphilitic lesions may present well-marked umbilication. The differential points are the history of the case, the more sluggish development of the syphilitic lesions, the grouping of the eruption, the absence of subjective symptoms, and the probable presence of other evidences of syphilis. It is very rare indeed that a disease so polymorphic as syphilis does not present a number of dissimilar eruptive elements at the same time.

Lichen.—*Papular Eczema* may be mistaken for the commencing eruption of small-pox. Five cases of lichen are reported in my list. Marsden states that "febrile lichen is more like small-pox, modified small-pox especially, than any other form of disease is, non-variolaous." It

must be observed, however, that the disease he alludes to as lichen febriles, or lichen agrius, is classified in our nomenclature as a form of eczema. It is exceedingly rare that an outbreak of eczema is preceded with severe febrile symptoms. The systemic disturbance, if at all marked, is consecutive to the general diffusion of the eruption over extensive surfaces. Eczema is further differentiated by the more intensely red, itchy character of the eruption, the size and color of the papules, its irregular distribution, and especially by the non implication of the mucous membranes.

Sudamina.—It would hardly seem probable that this eruption should be mistaken for small-pox, yet two cases, one of sudamina and one of miliary fever, were so reported. The dew-drop-like lesions of sudamina, their superficial character and greater abundance on covered parts, would serve to differentiate the eruptions. Moreover, the vesicles of sudamina attain their complete development in a few hours, and remain unchanged throughout their course. Dr. Jacobi reports the case of a woman in Bellevue Hospital, in which he was unable to make a positive diagnosis during the first four days of the disease. The body was profusely covered with a sudamina like eruption, the face being free, on fourth day her face became covered with an eruption, not characteristic, but sufficient to establish the diagnosis of variola. Dr. Janeway stated that similar doubtful cases are not rare.

Pemphigus and Herpes are recorded as having been mistaken for small-pox. In pemphigus, the larger size of the bullæ, their development upon an erythematous base, their hemispherical or globular form, and the rapidity of their evolution, would serve to distinguish them. The contents of the bullæ quickly become turbid or they readily burst, leaving excoriated surfaces; moreover, they come out in successive crops. Catarrhal herpes is a more or less constant attendant upon many febrile affections. The vesicles are always few in number, which, with their clustered character, their tendency to develop at the junction of the skin and mucous membranes, and the restriction of the eruption to these localities should serve at once to differentiate it.

Erythema and Urticaria.—It is only the papular forms of these diseases in which the eruptive element has any resemblance to that of small-pox. An attention to the invasive symptoms, the absence of fever, the localization, and other characters of the eruption, will serve to eliminate small-pox.

Acne has been mistaken for small-pox. In acne there is an entire absence of constitutional derangement, with no subjective symptoms.

The eruption is chronic in its course and limited to certain localities, papules and pustules are generally present at the same time, interspersed with comedones. The element of age is also a differential factor, as the development of acne is ordinarily limited to the period of early adolescence. The lesions are usually conical, and suppuration ordinarily occurs at the summit and not in the totality of the pustule. In the so-called acne varioliformis, or acne atrophica, the eruption is almost always confined to the forehead and margins of the hairy scalp. An artificial acne produced by the ingestion or external application of certain drugs has been mistaken for small-pox. Two cases of iodic acne recently came under my observation which had been diagnosed as small-pox, and the patients sent to the small-pox hospital, but were thence transferred to the skin ward of the Charity Hospital.

In concluding these hasty and imperfect observations upon this very important subject, I may refer briefly to the evidence of characteristic marks of vaccination as influencing diagnosis. In the case of a doubtful eruption, some physicians would be inclined to exclude variola if there were present no marks of a perfect vaccination. But clinical experience proves very conclusively that vaccination, no matter how efficiently and recently performed, does not prevent small-pox. I have already referred to the marked modification impressed upon the disease by vaccination. In some cases, however, it does not materially mitigate the severity of the disease. Kaposi states that vaccination affords no protection against hemorrhagic small-pox. "Purpura variolosa occurs as frequently in the vaccinated and unvaccinated and those who have passed through an attack of small-pox." The absence of all marks of vaccination, no matter how mild the symptoms, does not then necessarily exclude variola.—*Jour. of Cut. and Ven. Dis.*

TREATMENT OF IVY POISONING.—Dr. Augustine Brown calls attention to a specific remedy for ivy poisoning which he described eight years ago in the *Medical Record*. This remedy is bromine, which Dr. Brown has employed with unvarying success in seventy-five cases, using the following formula:

R. Brominii..... gtt. x-xx.

Ol. olivæ seu.....

Ol. amygdalæ dulc..... f ʒj.—M.

Sig.—Apply freely to affected surface four times daily. Wash with warm water and castile soap twice daily.—*Northwestern Lancet.*

THREE CASES OF INANITION. I have recently had an interesting experience with three cases of inanition in infants, and as weak stomachs in babies are so often the subject of the medical man's attention, have concluded to give my experience to the profession.

CASE I. C. S., male, aged ten weeks. Was present at the birth of this child, and at birth it was a strong, hearty child; but the mother having no milk, she commenced rearing the child on cow's milk. For a time the child thrived, but the extreme hot weather of last summer was too great a tax upon its digestive powers.

At the age of ten weeks I was called to see it. The mother told me that it had had a similar attack to the one I am about to describe, three or four days previously, but had partially recovered from it. Upon visiting the little patient, I found it constantly crying. It presented a shrivelled, pinched, mummified appearance, such as one never forgets after having seen it once.

I sat and studied this child carefully, and concluded that the child was not crying from pain, but from hunger, and that the entire trouble was inanition from lack of assimilation. I told the mother I did not think the child would live till I could get to town, a distance of five mile, and get some food out to it. I left a placebo to appease the anxious mother, and returned to the city. I had in my office a sample package of Carnrick's soluble food, which had been sent me a short time previously; I also had samples from several other manufactures, but chose Carnrick's, not because I had any more confidence in it, but because it could be prepared without using any milk.

The father took it home, and some of it was quickly prepared and given. From the first dose, the child ceased crying, and commenced thriving at once, very much to my surprise and that of all who saw it.

CASES II. and III. These may be considered as one case, being a pair of twins, born at the seventh month; I will designate them as babies Nos. 1 and 2

When these children were born I did not expect them to live, as they were very puny and feeble. When they were six weeks old I was called to visit them, and I found them in precisely the condition of the one previously described, except that there was not the continual crying.

One of them, which I will designate as No. 1, seemed much weaker than the other, in fact, it lay in a condition of stupor most of the time.

I had a small portion of the sample package of soluble food left, and ordered them to be fed with it an once. They commenced recover-

ing at once, and continued to thrive as long as the food lasted. In the meantime I had ordered the food from both St. Paul and Milwaukee, but could not obtain it in either city.

When the food I had left them was gone, and as no more of it was to be obtained, they were placed upon the use of another food, which is in very popular use for infants, but it failed to meet the requirements, and, though the greatest of care was used in its preparation, it was but two or three days before they commenced showing signs of inanition; but this time the one designated as No. 2 failed first, dying about a week after we had suspended the use of Carnrick's soluble food. The other died four days later.

In the case of these two infants the changes for better and for worse were so decidedly marked that there could be no question as to the effect of the foods, and the parents, as well as myself, are convinced that could we have had the soluble food to continue with both children would be alive to-day

About a month ago, C. S., case No. 1, commenced showing all of the evidences of a return of the old condition of inanition, though what caused it I could not learn. Not having yet obtained a supply of Carnrick's food, I prescribed the food that was substituted for it in the case of the other infants, but the child still failed.

In the meantime I had written a brother of mine in Chicago, who succeeded in obtaining some of Carnrick's food of Fuller & Fuller.

As soon as it arrived the child was fed with it, and the patient is now (two weeks later) nearly restored to its former plump, healthy condition.

If my fellow-practitioners will try this preparation, I can assure them that they will not only be pleased with it, but will save the life of many a little patient that would otherwise be sacrificed.—*Theodore L. Hatch, M. D., in Northwestern Lancet.*

THERAPEUTIC NOTES (J. J. BERRY, M. D., IN N. E. MED. MO.) The following items which are taken from my note book have been of such use to me that I am led to think they may furnish useful hints to others as well. Few of them are original, but have been derived from all possible sources and have been utilized by me to a greater or less extent.

Tonics should be administered with certain alteratives when given for long periods of time; for instance, quinine with mercury; cod-liver oil with iodide of potash; and iron with various salines.

Emetics are not given enough. Effects upon the liver and intestinal tract are often more obtainable in this way than by any other.

The diarrhea of phthisis is usually relieved by a pill of g. terebinth, cupri sulph. and opium.

The best treatment of engorgement of bronchial mucous membrane is to keep the bowels open.

The best respiratory stimulants are ammonia, atropia, strychnine, ipecac and squill.

Expectorant.—Eth. sulph., gutts. v-x every three or four hours.

Pruritus (general).—Potass. brom., grs x, potass. liq. gutts. x, three or four times daily.

Lumbago.—Potass. cit., grs xx ter die with hypodermics of morphine and atropia.

Salines act better after physiological doses of calomel.

The action of quina is increased by half drachm doses of bitart. of potash.

Belladonna or bromide of potash often prevents the disagreeable effects of iodide of potash.

Alcohol helps the organism to tolerate large doses of quinine.

The addition of alcohol to croton oil renders the latter less powerful but none the less effective.

Chorea.—F. E. cimicifuga in gradually increased doses.

Columbo checks colliquative diarrhea and relieves irritability.

Senega for the bronchitis and emphysema old people. Balsams act best in chronic diseases of the bronchial mucous membrane.

The secretion of urea is increased by sod. salicyl., sod. benzoat, colchichum and hydrarg. bichlorid, as well as by the salts of potash.

Salines have an increased cathartic effect if given in a concentrated form, withholding all liquids.

Iodine is one of the best anti-suppurative remedies. It has been used with success in typhoid fever and pneumonia.

Calomel, one half grain, is said to relieve dryness of tongue in six hours.

Tonsillitis.—Local applications of bicarbonate of soda.

The cough of phthisis is often relieved by remedies which act upon the liver.

Counter irritation of the neck, over course of pneumogastric nerves, will often relieve asthma.

Arsenic is one of the best tonics in chlorosis and the anemia of women.

A saturated solution of sod. bicarb. best relieves pain of cautery burns.

Acids best relieve phthisical dyspepsia.

Chloroform increases the secretions.

Chloral hydrate or chloroform water in painful affections of the stomach.

Grain doses of ipecac act as an hepatic stimulant.

The pains of spinal irritation are often relieved by arsenic.

Vaseline is much used for conjunctivitis.

Caffeine slows the action of the heart, increases the amount of urea and decreases the amount of albumen excreted.

Salicin will often relieve dysmenorrhea. It is of great value in tonsillitis and muscular pain.

Epilepsy.—A hypodermic of morphine will often abort a paroxysm.

Sick-headache.—A hot foot bath with a fifteen grain dose of chloral.

Hoarseness.—Tr. guaiac am. ten drops on sugar every half hour.

Salicylate of soda.

Weak heart.—Tr. stramonium and tr. digitalis, of each ten drops, three times daily.

Lead paralysis.—Large doses of strychnia.

Diarrhea (in teething children).—Infus. camomile.—Columbo.

Regurgitation (of infants).—Calomel gr. j; aq Oj; teaspoonful every 15 min.

Eruclation, Pyrosis and Fermentation.—Ac. carbol, gr. i-ii in mint water.

Inhalations of steam impregnated with oil of peppermint is almost a specific in relieving painful affections of the throat.

Calomel is one of the very best remedies in many of the acute diseases of children; the latter are so very tolerant of the drug that it is almost impossible to salivate with laxative doses. Its antipyretic effects and its sedative action upon the intestinal tract is fully appreciated only by those who have used it.

The value of carbonate of ammonia in the respiratory diseases of children is not fully recognized. It should be given in large doses well diluted in milk.

Ovarian pain is best relieved by belladonna, arsenic, valerianate of zinc and carbonate of iron.

Muriate of ammonia relieves congestion of the pelvic viscera.

Permanganate of potash in two grain doses is an excellent emmenagogue for strumous subjects.

TREATMENT OF ANGINA PECTORIS. —Huchard by his novel treatment, based upon his undoubtedly correct pathological views, records a greater number of cures of true angina than any other clinician has ever obtained previously (twenty cures). His treatment consists principally in the exhibition of iodides, which, as is well known, are alone able to cure the affections of the arterial system, even those of a non-syphilitic nature. The iodide of potassium, or better, of sodium, given without intermission for months, and even years, in a daily dose of 1 to 2 grammes (15 to 30 grs.), will with certainty at first diminish the frequency and intensity of the anginal paroxysms, and finally bring about their definite and complete disappearance.

The curative effects of the iodides of sodium and potassium in aneurism of the aorta and various other arterial affections show the powerful influence of the iodine treatment on pathological conditions of the vascular apparatus.

In aortitis, both of the acute and chronic type, we find most frequently dilatation of the aorta and elevation of the subclavian artery. Under the influence of the iodine treatment both symptoms can be relieved promptly and permanently.

The most refractory cases in regard to this treatment are those in which the aortitis and the arterio-sclerosis approach their termination, for the iodides, however powerful they are, cannot suppress an arterial atheroma. In general, it can be said with propriety that "the iodides are the digitalis of the arteries." Huchard's routine formula is:—

R Sodii iodidi.....gr. cl.
 Aquæ destil..... fʒi j.
 Fiat sol.

Sig.—Two to four teaspoonfuls daily, to be taken in a cup of tea.—
Therap. Gazette.

SYMPTOMS AND PATHOLOGY OF POISONING BY PTOMAINES, OR CA-DAVERIC ALKALOIDS.—The attack occurs in the majority of cases in from eighteen to twenty-four hours after the introduction of the poison into the system. The symptoms, as collected from a large number of cases, are pain and a sense of weight in the stomach, vomiting and diarrhea, extreme prostration, dry condition of the mucous membranes of the mouth

and throat, irregular pyrexia, dysphagia, vertigo, aphonia and noises in the head. Double vision, ptosis, dilated pupils, scarlatiniform rash, muscular twitchings and tetanic spasms are of frequent occurrence. Rudolph Boehm says it is, after the acute symptoms have subsided, essentially a kind of typhus, continuing a tedious course for weeks, with symptoms that indicate morbid blood processes and changes in nerve centers not unlike those in diabetes mellitus. Weak pulse and cold skin characterize the latter stages of the poisoning. In the rapidly fatal cases, death results from paralysis of the respiratory muscles. Pneumonia, nephritis or some other complication may supervene. Patients often make very slow recoveries. Death usually occurs on the fifth or sixth day after poisoning. In the acute stage death occurs in the majority of cases in from twelve to twenty-four hours. In forty-eight fatal cases reported by Boehm, six died on the first day, two on the second, four on the fourth, three on the fifth, two on the sixth, eight on the seventh, five on the eighth, three on the ninth, eight on the tenth, two on the thirteenth, one on the fourteenth, one in three weeks, and three died at still later dates.

The pathological conditions in man, so far as observed, are quite identical with those produced by the action of ptomaines on lower animals. The mucous membranes of the esophagus, mouth and stomach are either hyperemic or dry and parchment like. The liver, spleen and brain are more or less hyperemic; ecchymoses are sometimes found in the stomach. The kidneys are congested with some effusion of blood into the tubuli. The lungs are often congested, edematous and pneumonic, with the tubes partially filled with a bronchial exudate.—J. U. Barnhill, M. D., in *Cleveland Med. Gazette*.

CHLORAL HYDRATE LOCALLY. The local application of chloral hydrate is very serviceable in many diseases, both on account of the relief of pain afforded and the cleansing of the parts. For cancerous ulceration of glands and of the uterus, phagadenic ulcerations, eczema, impetigo, ulcerated legs, herpes zoster, pleurodynia and neuralgia, local employment of chloral, half an ounce in a pint of water, with a little glycerine, has been productive of much benefit. Ulcerated surfaces become healthy by comparison, discharges less offensive and pain is reduced to a minimum. These results are probably due to direct action on the peripheral nerve terminations.—*Med. World*.

SURGERY.

SOME APHORISMS IN OPHTHALMOLOGY.—(M. F. COOMES, M. D.)

1. As a local anesthetic to mucous surfaces and open wounds, the muriate of cocaine is one of the most certain and effective agents that is known.

2. All surgical operations on the eye, except enucleation of the globe, may be performed under the influence of cocaine with as much or more safety than under other anesthetics.

3. In all forms of iritis keep the pupil dilated.

4. In acute retinitis unaccompanied by iritis, keep the pupil contracted, in order to keep out as much light as possible.

5. The only relief for senile cataract is surgical interference.

6. The rule is that all acute purulent discharges from the conjunctiva are contagious.

7. The only proper method of testing the vision in persons possessing the power of accommodation, is to suspend that power by paralyzing it, and then pursue the usual method with the trial lenses.

8. Jequirity is a dangerous remedy as well as an unreliable one, and should not be used by unskilled persons.

9. All kinds of strong caustic applications are contraindicated in the treatment of acute purulent inflammations of the conjunctiva.

The best results are obtained by frequent cleansing with mild saline solutions, and the use of weak solutions of the vegetable or mineral astringents (excluding nitrate of silver), a solution containing five grains of tannic acid and three grains of carbolic acid to the ounce of water, or from one half to one grain of the sulphate of copper to the ounce of water will be found among the most efficient agents.

10. It is always good surgery to remove a foreign body from the eye, provided it is not entirely within the globe behind the iris. If a foreign body is between the iris and the cornea, prompt removal is urgently demanded.

Great care must be taken in order to avoid wounding the lens, as such an accident would be certain to result in the production of cataract. If the foreign body should be entirely within the globe behind the iris, or if it should be large and partially within the globe, the question to be settled is, whether it will be best to remove the eye or the foreign body.

If the laceration of the globe is not too great it will probably be best to remove the foreign body, and then if the globe becomes violently in-

SELECTIONS

lamed, or a sympathetic inflammation of the other eye should occur, remove the ~~lamed~~ member without delay.

~~It is not intended for~~ purposes, and is painful,
~~and it is not intended for~~ may induce inflammation in the
~~and it is not intended for~~

modules about the margin
almost absolute evidence

should be performed, if possible, in an atmosphere of influence so thoroughly relaxed that the subject is able to determine when the operation

and is protruding, it should be cut off,
of a mydriatic until the inflammation

... could never attempt to replace a protruding
... difficult, and there is great danger of
... cataract

... is the only means of giving permanent
... will give temporary relief, and cocaine relieves

Two efficient agents in tenia-tarsi is an ointment
 of two grains of the yellow oxide of mercury to one
 of lard, or some other suitable vehicle. This is to be
 used night and morning after thorough cleansing.

... of every description are to be avoided in diseases of
... by some one who is specially skilled in this line

However there is great edema of the conjunctiva, and when this is associated with excessive purulent discharge, the tarsus should be snipped in numerous places so as to permit the pent up exudate to escape, and thus prevent destruction of the cornea, which is the danger in such cases. Remember that there can be no harm in this cutting, and if it does not give the desired relief, a tarsorrhaphy should be done.

20. In the majority of cases of strabismus, glasses are necessary as well as treatment, inasmuch as the strabismus in most instances is dependent on an optical defect which, if uncorrected, would cause a return of the squint. It is always better to correct squint by means of properly ad-

It is always better to correct squint by means of properly adjusted lens than by tenotomy:—*Med. Herald.*

PROPOSED MODIFICATION OF PIROGOFF'S OPERATION. At the recent congress of Russian practitioners, Professor Tauber described and demonstrated on the dead subject an operation for removal of the foot, which he believes has several advantages over Pirogoff's amputation. Standing on the outer side of the limb, he commences an incision at the insertion of the tendo Achillis, and carries it forward just below the external malleolus to the dorsum of the foot, and then vertically downwards on the inner side in front of the heel. When the middle line of the sole is reached, the incision is carried along it backwards and prolonged upwards to the starting point at the insertion of the tendo Achillis, a flap having thus been cut, consisting of the inner side and half the sole of the heel. The joint is then opened, the external ligament being first divided and then the internal. The astragalus is seized with the bone forceps and removed, nothing being left but the os calcis, the soft covering of which on the inner aspect is untouched. The os calcis is seized with the bone forceps and turned so that the articular surface is towards the operator. The forceps are now taken by an assistant, who holds them tightly; the operator then saws the bone longitudinally in two, the outer half, which is free, is removed, the inner half remaining attached to the flap. The ends of the tibia and fibula are then sawn off just above the malleoli. The cut surfaces of these will be found to correspond almost exactly with that of the os calcis, which is now brought into apposition with them. The advantages claimed for this operation are: 1. The posterior tibial artery itself is untouched, only its branches being divided. 2. The insertion of the tendo Achillis, as well as its bursa, are not injured. 3. The surface of the os calcis and of the leg bone correspond very nearly to one another.—*Lancet*.—*Maryland Medical Journal*.

[The operation of Professor Jarvis S. Wight, of Brooklyn, has all the above advantages, besides being simpler and not necessitating the opening of the ankle joint. Two incisions are made from one malleolus to the other, one incision extending in front of the ankle joint and the other under the heel. The os calcis is sawn through from below upwards, and then the tibia and fibula just above the articular cartilage. This operation is simple, efficient and quickly done. The originator calls it the lowest possible amputation of the leg with a piece of bone in the posterior flap. A. H. P. L.]—*Amer. Digest*.

SELECTIONS.

OBSTETRICS.

STATISTICS OF THE LYING-IN CLINIC.—Dr Emil Ehrendorfer, writing of the statistics of the Lying-in Clinic here, for the year 1882, 1883 and 1884, has furnished us with some very interesting data. In 1882 the ~~perinatal~~ mortality was 0.51 per cent; in 1883 0.33 per cent; and in 1884 it was 2.32 per cent.—this including three cases of Cesarean section. Puerperal fever in 1882 occurred in 4.31 per cent., in 1883, in 3.59 per cent., and in 1884, in 3.08 per cent., while other pathological diseases resultant upon labor fell from 6.17 per cent. in 1882 to 4.87 per cent. in 1884; and all this from a strict attention to antiseptics and cleanliness in every possible detail. In these matters few people have a riper experience than Dr. Ehrendorfer. As first assistant to Prof. Spaeth he is responsible every year for about 3000 labors.

One is very much struck here with the rarity of perineal lacerations. The matter becomes plain, however, when one sees with what tact the perineum is handled during labor. The woman rests on her back until the head presses upon the vulva, then she is turned upon her left side, with the buttocks resting upon the edge of the bed, the legs well drawn up and kept apart either with a pillow or by an assistant. The nurse sits on the right side of the bed, with her back to the face of the patient; the left hand is passed over the right thigh of the patient, and manipulates the child's head; the free right hand of the nurse keeps the perineum moist with catholised water, and assists the left hand. The patient is enjoined not to bear down, and the head is kept back forcibly, so as to prevent a too sudden birth. The fingers of the left hand are occasionally passed around the presenting part of the fetal head, just inside the labia, or the head is gently moved toward the symphysis by a well directed action of the left hand. The main thing is to keep the perineum moist and to keep the head back. If there is thinning of the perineum, and a danger of laceration either lateral or bilateral, episiotomy is resorted to. If there be immediate danger of a central rupture, an incision is made from the posterior labial commissure, creating a laceration of the second degree, which is operated on immediately after labor. Lacerations of the first and second degree, and even sometimes of the third degree, are operated on immediately after the birth of the child, except when the woman's condition contra-indicates such a procedure. For all minor lacerations sutures are used. I have seen several cases of hydramnios lately, and apart from other methods, the curves made with the women in different positions are quite sufficient to distinguish this condition from others which may simulate it. *Am. Med. Digest.*

COLUMBUS MEDICAL JOURNAL.

EDITORIAL.

Heating and Ventilating.

The connection of the heating of a house with its ventilation is, of course, inseparable. Many persons will cheerfully expend ten or fifteen thousand dollars in building a house, putting from two to three thousand on outside ornaments, who would not dream of spending five hundred or one thousand dollars for the necessary Hot Water Apparatus to keep this same house thoroughly and comfortably warmed and well ventilated.

In reading the reports from the various Boards of Health, one can not fail to notice the startling increase in the death rate from Scarlet Fever, Diphtheria, and allied diseases. It might safely be said that this condition of affairs is due to the fact that the tightly closed doors and windows, which cold weather makes necessary, prevents the ventilation of houses, which is essential to the maintenance of health.

To those who intend erecting a dwelling, we would advise that the matter of heating and ventilating be given much consideration; and before deciding how it shall be done, consult the A. A. Griffing Iron Co., Manufacturers of the Tompkins Hot Water Indirect Radiator, 518 Communipaw Ave., Jersey City, N. J.

Forms of Hydrastis.

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The use of this drug as a therapeutic agent was first gained through its employment in the treatment of the "white cholera," and in the fifty years following its introduction into medicine, its use has been made by manufacturers to perfect a preparation which contains all the active principles of the drug, without the high price of the salt.

It is a well-known fact that the writers on *Materia Medica*, accord to the late Wm. S. Merrell the credit of being the first to introduce Hydrastis preparations, and to the present organization of being the largest consumers of the drug in the world. For more than twenty years Hydrastis has been made a study in our laboratory, and we do not think it an exaggeration when we assert that it stands pre-eminent to-day as the most valuable of our vegetable *Materia Medica*.

Our preparations in fluid form are receiving our special attention at this time.

Fluid Hydrastis—MERRELL.

Fluid Hydrastis implies—the active, medicinal principles of the drug in natural combination in a fluid form. It has a bright, yellow color, perfectly clear, free from sediment, and an unmistakable odor of the fresh drug.

Fluid Hydrastis is a pure, neutral solution of all the alkaloidal constituents of the drug, free from the oil, gums, irritating and offensive resins and inert extractive matters. The success of its introduction is the best evidence of its therapeutic value.

Successful imitations and would-be substitutes are met with on every hand. Preparations are to be "just as good" or "about the same thing," but always "a little cheaper." The wide-spread and growing popularity of Fluid Hydrastis. All such, compared with the original, as to physical appearance or as representatives of the drug, are condemned; and in prescriptions, they are readily detected; tested therapeutically, they are prompt and unworthy of confidence.

Fluid Hydrastis is applicable to the treatment of all irritable, inflammatory and ulcerous conditions of the mucous tract.

This statement of a well-known medical writer and journalist has become axiomatic: "No remedy for physician's use has been received with such universal approval."

Solution Bismuth and Hydrastia—MERRELL.

An invaluable and scientific combination, wherein the beneficial action of the white alkaloid is increased by association with Bismuth. This solution contains $2\frac{1}{2}$ grains of the white alkaloid and Hydrastia; twenty-five per cent. of which is Hydrastia Citrate.

The official recognition accorded this preparation marks it as the most valuable combination in the market in which the white alkaloid alone represents the valuable properties of the drug. And in diseases of the nasal passages, of the eye, of the throat, of the stomach and intestines, of the reproductive organs and bladder it is equally beneficial.

Colorless Solution of Hydrastia—MERRELL.

This is a permanent solution of the white alkaloid, without the addition of any other ingredients to modify or increase its action. It is offered without special recommendation, and the views of an unlimited number of physicians, with whom the color of the Fluid Hydrastis is an objection. This solution contains in one fluid pint the same proportion of the white alkaloid as exists in an average quality of crude root.

Compare above on Solution Bismuth and Hydrastia.

Merrell's Hydrastis Preparations are for sale by Wholesale Druggists throughout the United States. Please specify "Wm. S. M. Chem. Co." in ordering or prescribing.

The WM. S. MERRELL CHEMICAL CO.,

CINCINNATI

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STATE SOCIETY NOTES.

THE meeting at Akron was quite well attended, and the programme, though unusually full, was pretty thoroughly carried out. Very little extraneous matter was brought in, and that little was promptly disposed of. Indeed, promptness and dispatch were prominent features of the session, to which the absence of all local attractions largely contributed. There was not even a promenade concert to relieve the monotony of the printed programme, and the only refreshments tendered were those offered by the "Baby food" men. But the Society heaped coals of fire on the heads of their inhospitable hosts by electing one of their number to the presidency.

A RESOLUTION was adopted, authorizing the insertion in the *Transactions* of engravings of all the ex-presidents of the Society. A good steel engraving costs from one hundred to three hundred dollars. To insert good engravings, therefore, would bankrupt the Society; to insert cheap ones would disgrace it; while some are cynical enough to assert that neither kind would particularly honor it.

BUT the most utterly unwise thing the Society did, was to adopt a resolution authorizing the expenditure of a hundred dollars in conducting ozone observations! These observations have been conducted, in one part of the world or another, for the past thirty years. Michigan has a very full record for many years. But not a single fact of any importance has been established, even approximately. The curve of ozone intensity corresponds with that of no disease whatever, unless by accident and temporarily. Even if a connection between it and certain diseases could be established, what then? We are powerless to either increase or dimin-

ish its quantity in the atmosphere. While so many directions remain in which fruitful researches can be conducted, the folly of spending either time or money on ozone testing cannot but be evident. The entire matter should have been referred to the State Board of Health.

LAPAROTOMY was a fruitful theme; no less than three papers being presented on that subject. That those were all presented by *young men*, was not the least noticeable feature of the occasion. It is very evident that there is a poor prospect in Ohio for the evolution of great ovariologists. In every part of the State are young surgeons, and old ones too, who are anxiously waiting, and hoping, for an opportunity to hang to their belts an ovarian scalp or two; the result being that no one operator can get more than a limited number of cases. Since the adjournment of the Society, three ovariectomies, at least, have been done in Columbus. Dr. Halderman operated early in June, before a number of students and physicians at St. Frances Hospital. The tumor was a large one and the patient much reduced. Notwithstanding the occurrence of peritonitis, his patient made a good recovery. He operated again about a week ago, at the same place, removing a round-celled sarcoma. The patient was sixteen years old, and the tumor was of the right ovary. Just as we write we learn that the case is doing well in every respect. About the middle of the month, Dr. Baldwin operated, removing a moderate-sized tumor from a single lady, aged twenty-five years. Recovery followed without the slightest evidence of inflammatory reaction, the temperature never rising above the normal range.

PERITONITIS.—Tait has just published his ovariectomy statistics for the years 1884-5. They embrace 139 cases, WITHOUT A SINGLE DEATH! Such figures are utterly marvelous: they are almost incomprehensible.

To account for this success it is necessary to look beyond his personal skill, for other operators are doubtless as skillful as he, and in thus looking we find one peculiarity in his method of operating, and one in his method of treating peritonitis. The peculiarity in his operating is his washing out —*flushing*—the peritoneal cavity instead of cleansing it by sponging. His short incision is a noticeable feature, to be sure, but certainly an inch or two, more or less, in the length of a clean incision is not so very essential.

But we think the most important clue to his success is to be found in his treatment of peritonitis. Opium, which has been regarded as the

sheet anchor for generations past, is rigidly excluded, but on the first appearance of inflammatory symptoms the patient is at once given a *quickly acting cathartic*, no matter what, but preferably a dose of salts, and the peritonitis is "conquered." Opium has been called "the splint of the bowels," and by its use we have endeavored to keep the bowels at rest until the inflammation should subside. But the peritonitis which follows laparotomy is usually of a septic nature, and seems to kill chiefly by the profound impression produced upon the sympathetic nervous system, causing paralysis of the intestinal muscles, distension of the bowels, and an interference with the functions of absorption and elimination. Opium relieves the pain, and, by masking the symptoms, lulls the patient and physician into a state of fancied security; but in reality its tendency is to add to the conditions that are already so threatening. On the contrary, a saline purge stimulates the muscular coat, relieves the tension on the peritoneal membrane, expels the flatus or causes it to be absorbed, and reestablishes the function of elimination: its use, then, is clearly and physiologically correct, and this method of treatment bids fair to largely diminish the mortality not only of laparotomy but also of the puerperal state.

STATE BOARD OF HEALTH.—The June meeting was held at Cleveland on the 15th. The resignation of Dr. Ashmann as Secretary was accepted and Dr. G. B. Case elected to the position. Dr. Case was Health Officer of Cleveland for two years, and in charge of the U. S. Marine Hospital.

In the regular order of business the reports of Standing Committees were read, and through them, communications of interest were presented. One from Adams county in regard to a case of small-pox, and one in regard to the epidemic of typhoid fever at Bellaire, O. Three hundred cases are reported in a town of only six thousand people. A committee, formed of Drs. Sharp and Wise, was appointed to visit Bellaire. The State of Ohio was divided into seven districts, and to each member of the Board was assigned a group of counties. The object of this was to establish Local Boards of Health throughout the State, in order that the reports on Vital Statistics and those of various diseases may be more complete.

To Dr. W. H. Critcher was assigned the N. W. counties; Dr. T. Clark Mills, the Eastern counties; Dr. S. P. Wise, the N. E. counties; Thomas C. Hoover, the S. E. counties; Dr. H. J. Sharp, the Central

counties; Dr. D. H. Beckwith, the Lake counties, and Dr. John D. Jones, the Western and South Western counties.

Notices will be sent to various members of the profession and some of the laity, asking their cooperation in the work of the Board.

THE American Rhinological Association will hold its fourth annual meeting at St. Louis, Mo., on the 6th of October next.

IN the July number of The Forum, Bishop Spalding discusses the question, "Are we in danger of revolution?" Professor Adams "Shall we muzzle the Anarchists?" and President Seelye "Should the State teach religion?"

IN MEMORIAM.

DR. HUGH C. STEWART.

Born May 26th, 1805; died April 1st, 1885. Dr. Stewart came to Ohio from Hagerstown, Md., while still a child. He removed, in 1827, to Bloomingburgh, Fayette county, Ohio, where he spent the remainder of his life, and where he died. In September, 1828, he was married to Miss Sarah Allibone, of Philadelphia. In the winter of '42 and '43 he attended lectures at the Ohio Medical College, Cincinnati, and the next spring began the practice of medicine, and from that time until his death was untiring in the discharge of the duties of his profession. He was the first physician west of the Allegheny Mountains to make use of chloroform as an anesthetic, allowing the patient to inhale it through the spout of a tea-pot, on the 27th of October, 1843.

In February, 1883, he fell on the icy side-walk, and struck upon the back of his head, and from this accident his death could be clearly traced. His last professional visit was made in January, 1885.

Dr. Stewart was a man of singular unselfishness and generosity; his whole life was an illustration of the golden rule, and the key-note to his character was found in his religious convictions. On all questions of reform, social or political, he was an advanced and independent thinker; he was the advocate of total abstinence when social drinking was the rule; was a pioneer of the anti-slavery movement, when to befriend the fleeing slave was to court the vengeance of the Fugitive Slave Law.

F. A. S.

REVIEWS AND BOOK NOTICES.

Handbook of Practical Medicine. By D. Herman Eichhorst, Professor of Special Pathology and Therapeutics in the University of Zurich. Vol. I. Diseases of the circulatory and respiratory apparatus. 103 wood engravings. Cloth: pp. 407. New York: Wm. Wood & Company. 1886.

This is the March number of Wood's Library for 1886. The volume is well illustrated for the purposes of physical diagnosis, for appliances and methods of treatment, and for showing pathological changes. We commend the book to student or practitioner as being fully up to the times.

A Compend of Pharmacy. By F. E. Stewart, M. D., Ph. G., Quiz-Master in Chemistry and Theoretical Pharmacy in the Philadelphia College of Pharmacy; Demonstrator and Lecturer on Pharmacology in the Medico-Chirurgical College, and in the Woman's College, Philadelphia. 12mo.; 196 pages. Philadelphia: P. Blakison, Son & Co. 1886. Columbus: A. H. Smythe. Price, \$1.00.

This little book is No. 11 of the Quiz-Compend Series. All of the books of this series have been prepared with much care, and are justly held as being far above the average compends. This Compend of Pharmacy is based, by special permission, on Prof. Joseph P. Remington's "Text Book of Pharmacy, which is now the acknowledged standard authority. The author and publishers have given much time towards making it as complete and concise as possible, and in arranging the types and paragraphs so that it may be easily and quickly referred to, and it will be found a useful guide to the tyro and worker in pharmacy.

A Treatise on Bright's Disease of the Kidneys. Pathology, Diagnosis and Treatment. With chapters on the Anatomy of the Kidney, Albuminuria, and the Urinary Secretion. By Henry B. Millard, M. D., A. M., Member of the N. Y. County Medical Society, etc., etc. Second Edition. Revised and Enlarged. New York: William Wood & Co. 1886.

We gave this book a very favorable notice in 1883, when the first edition appeared. The book is the outcome of the author's large experience, both in hospital and private practice. The first seven chapters are taken up by an account of the minute anatomy and physiology of the kidney, and the remainder of the first part is occupied by a description of the pathology of the kidney and urine. In the second part the treatment of the various diseased conditions is considered. In the discussion

of the many remedies which have been recommended, the author evinces great practical experience, and gives sound, common-sense views on the alleviation and cure of this class of disease. We can commend the book to our readers as thoroughly scientific, reliable, and practical.

The Student's Manual of Venereal Diseases. By Berkeley Hill, M. D., Professor of Clinical Surgery, University College, London, etc. and Arthur Cooper, M. D., Surgeon to the Westminster General Dispensary, etc. Fourth edition, revised, 132 pp., duodecimo. Cloth, \$1.00. Philadelphia, P. Blakison, Son & Co. 1886. Columbus: A. H. Smythe.

The account of the venereal affections here presented is sufficient to give the student a correct outline of their history, methods of contagion, manifestations, sequelæ, and treatment. Within the space allotted, the authors have done better than could have been expected.

The Principles and Practice of Medicine. By the late Charles Hilton Fagge, M. D., F. R. C. P., Physician to, and Lecturer on Pathology at Guy's Hospital; Examiner in Medicine in the University of London; Senior Physician to the Evelina Hospital for Sick Children, etc. Including a section on Cutaneous Diseases, by P. H. Pye-Smith, M. D., F. R. C. S., Lecturer on Medicine at Guy's Hospital; Chapters on Cardiac Diseases, by Samuel Wilkes, M. D., F. R. S., Physician to Guy's Hospital and to the Royal Hospital for Children, London; and complete indexes, by Robert Edmund Carrington, M. D., Assistant Physician to Guy's Hospital, London. Volume II. P. Blakison, Son & Co., Publishers, Philadelphia, 1886. Columbus: A. H. Smythe.

The very favorable notice of Volume I, of this most excellent work, which recently appeared in our columns, is fully applicable to its successor. The second volume, indeed, gains additional value by reason of the chapters on chronic endocarditis, by Samuel Wilkes, M. D., and a section on cutaneous diseases, by P. H. Pye-Smith, M. D. These chapters are not superior to the rest of the book, but they fill the gaps left by the untimely death of the author, and render his work complete in all particulars. The two volumes together constitute a most enduring monument to the memory of their gifted author.

The Genuine Works of Hippocrates. Translated from the Greek, with a Preliminary Discourse and Annotations. By Francis Adams, LL.D., Surgeon. In two Volumes. Volume I. Being Vol. IV of Wood's Library for 1886. New York: William Wood & Company.

Dr. Adams was appointed to the task of translating and editing the works of Hippocrates by the Sydenham Society. Two volumes, of which

the one before us is the first, will include the whole of those treatises now regarded as genuine. The first 125 pages, by the editor, on Origin of Medicine, Physical Philosophy of the Ancients, etc., is very interesting. These works have heretofore been practically inaccessible to the great mass of medical men, who cannot but be delighted, as they now find them presented in good English, with all necessary explanatory notes and illustrations.

Insanity and its Treatment. Lectures on the Treatment, Medical and Legal, of Insane Patients. By G. Fielding Blanford, M. D., (Oxon.), Fellow of the Royal College of Physicians in London; late Lecturer on Psychological Medicine at the School of St. George's Hospital, London. Third Edition. To which is added Types of Insanity. An Illustrated Guide in the Physical Diagnosis of Mental Disease. By Allan McLane Hamilton, M. D., one of the Consulting Physicians to the Insane Asylums of New York City, and the Hudson River State Hospital for the Insane. Illustrated by ten full-page plates from photographs of cases selected as types, with descriptive text. Vol. II of Wood's Library for 1886. New York: William Wood & Company.

These Lectures were originally delivered before the students at St. George's Hospital. Afterwards reproduced in book form, they have now passed to their third edition. It constitutes an important and valuable portion of the Library. "Types of Insanity," by Allan McLane Hamilton, M. D., includes ten large plates, from instantaneous photographs, and five chapters on the general appearance of the insane, the condition of special organs, the condition of bodily functions, the examination of patients, and the commitment of insane, with abstract of laws in various States. The volume is thus made American as well as English.

Diseases of the Spinal Cord. By Byron Bramwell, M. D., F. R. C. P., (Edin.), Lecturer on the Principles and Practice of Medicine, and on Medical Diagnosis in the Extra Academical School of Medicine, Edinburgh; Pathologist to the Edinburgh Royal Infirmary, etc., etc. Illustrated by fifty-two full-page lithographic plates, in colors, and many fine wood engravings. New York. William Wood & Co.

This is the first volume of Wood's Library of Standard Medical Authors for 1886. The subject treated of is at the same time one of the most important, as well as most obscure, in the science of medicine. Yet the author has handled it well. He places great stress on the early diagnosis of spinal lesions, as they are most amenable to treatment—whether curative or palliative—in their earliest stages. The section on "Railway Spine" is especially valuable. The work is well illustrated.

Diseases of the Digestive Organs in Infancy and Childhood, with chapters on the Investigation of Disease, and on the General Management of Children. By Louis Starr, M. D., Clinical Professor of Diseases of Children in the Hospital of the University of Pennsylvania, etc. 385 pp., octavo. Cloth. Philadelphia: P. Blakiston, Son & Co. 1886. Columbus: A. H. Smythe. Price, \$2.50.

The author could hardly have chosen a subject in which all practitioners are more interested. Infants with disordered digestion are, like the poor, always with us, and their treatment is, as a rule, by no means particularly satisfactory.

After some general instructions as to examinations, etc., the author takes up the affections of the mouth and throat, whence he passes to those of the stomach and bowels. *Tubes mesenterica* receives special consideration. A separate chapter is devoted to diseases of the liver, and another to those of the peritoneum. The last forty pages explain the general management of infants with reference to feeding, bathing, clothing, sleep and exercise.

There are a number of illustrations. The material of the work has been drawn from careful observation, and this gives it a freshness which will be appreciated by all.

The Principles and Practice of Surgery. By Frank H. Hamilton, M. D., LL. D., late Professor of the Practice of Surgery with Operations, and of Clinical Surgery in Bellevue Hospital Medical College; Consulting Surgeon to Bellevue Hospital; to the Bureau of Surgical and Medical Relief for the Out-door Poor at Bellevue Hospital, etc. Illustrated with 472 engravings on wood. Third edition, revised and corrected. New York: William Wood & Co. 1886.

The first edition of the work was issued fourteen years ago. The author is well known, not only as one of the most accomplished surgeons of modern times, but also as the author of the best work on fractures and dislocations in any language. The twelve years that have elapsed since the previous edition was issued, have seen gigantic strides made in surgery, and the author has therefore either thoroughly revised, or entirely re-written the entire work.

As announced in his preface, he has aimed to discard all historical and theoretical discussions, and to confine himself to the description of those methods which his long experience has proved to be the most satisfactory. Hence the tone of the volume is, throughout, eminently practical, and by such limitation he has presented the whole domain of surgery within the compass of one volume of moderate magnitude.

His work will be found to fill the want, that many have felt, of a comprehensive work on surgery in a single volume.

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COMMUNICATIONS.

TREATMENT OF CARBUNCLE.

BY NORMAN GAY, M. D., COLUMBUS, OHIO.

A paper read before the Ohio State Medical Society, June, 1886.

An apology may be in order, for offering a short article on the treatment of Carbuncle, since so many articles have appeared in the medical journals of late.

During the session of the American Medical Association at New Orleans, in 1885, an article was read on the treatment of Carbuncle, the main feature of which was to condemn the practice of incisions, crucial or otherwise, as a means of relief, or cure, claiming that it was not only unnecessary, but that they did harm by causing loss of blood, and greatly increased the pain and largely interfered with the progress of recovery; the gentleman closed by recommending such treatment as any old lady would use, which, after many weeks of suffering, (if the patient could stand it) would end in recovery, although large numbers have died under such treatment.

Subsequent to this, two other articles have appeared in two journals recommending a similar plan of treatment, none of which convey any idea of checking the course of the disease, or producing a rapid recovery.

In the past two weeks, two articles have appeared in our periodicals, one by Dr. Taylor, of Toledo, recommending injections of pure carbolic acid into the small opening, or sinuses, of the Carbuncle, with the hypodermic syringe, and he claims for his plan of treatment immediate relief from pain, and that it also checks the course of the disease, and recovery is more rapid, with a much smaller eschar, than when the old plan of treatment is followed.

Then comes a gentleman from Texas who has followed this plan for some years, and always with good results, rapid recovery, small eschars and a minimum of pain.

Without further digression, I will give the history and treatment, with the results, of a few cases. In the spring of 1868, a young man came to my office with a Carbuncle over the right scapula, at the upper edge of the *Latissimus dorsi* muscle. The boggy part in the center of the diseased area was about one inch in diameter, with several sinuses leading through the skin. The young man had been drinking hard and was out of both money and clothes; he had just received an appointment as clerk in some department at the State house, and was obliged to work or starve. I injected into the boggy part of the sore a few drops of carbolic acid and olive oil, equal parts, then applied over the sore lint wet with carbolic acid, olive oil and chloroform, equal parts of each, placing over this tissue paper, held in place by straps of adhesive plaster. This was on a Sunday morning. Monday morning he went to his work and continued to work until the close of his appointment. The sore had completely healed at the end of two weeks, and after the first injection no pus was formed.

In the fall of 1878, I was requested to see Mr. S. G., aged 72, by Dr. Stein. The patient was suffering from a large carbuncle on his back. It commenced a little to the left of the spine, and about the middle of the scapula, and had extended slowly until it measured 10 inches in diameter. Its growth had extended over a period of nine weeks, and at that time quite a large slough had formed, leaving a large part of center bare of skin, and with but a slight attempt at repair. The man was quite feeble but had been of good habits, although possessing but few of this world's goods. In this case I changed the plan of treatment, by injecting a solution of carbolic acid—one to seven—under the skin all around the tumor, using about half of an ordinary hypodermic syringe of the solution at each point, and making the injections from one to two inches apart. This completely arrested the course of the disease, except

at two points; these were injected again, after which the patient had but little pain, and recovered as rapidly as could be expected from a person of his age. I should say that prior to this treatment, he had taken quinia, iron, with a generous diet, and had applied various ointments, poultices, etc., etc.

From this time until 1883, I had treated several cases, but none so large or of such duration, but all in the same manner, and in each case arrested the course of the disease and invariably secured a rapid recovery.

In February 1883, I was called to Milford Center, by Dr. Boylan, to see a Mr. W., whose age was about 52. He was a man of good habits, and was surrounded with all of the comforts of life; in fact, he was what is called a "good liver." Some six weeks prior to my visit, he had called at Dr. Boylan's office on account of a boil, as he supposed, on the back of his neck. Not finding the Doctor, he returned home, and for the next three weeks applied all kinds of poultices that himself and neighbors could invent, using as internal remedies, tinct. opium and Dover's powders. At this time Dr. Boylan was called in; the tumor was about four inches in diameter, with a boggy place one and a half inches in diameter. The Doctor pursued the usual plan of treatment recommended, except incision, having tried that before, and not being pleased with the result. The disease under the Doctor's treatment continued to spread, and at the end of two more weeks was seven or eight inches in diameter, with a boggy spot of over three inches in diameter. He had lost the use of his right arm, sensation in that member was very much impaired. Half grain doses of morphia were required every four hours, which, with whisky, quinine and iron, only gave partial relief. The sore had been washed with a weak solution of carbolic acid three times daily. Poultices had been applied, but notwithstanding all that had been done, the disease marched steadily along, from bad to worse, and it looked like our patient would succumb to its influence. We first applied over the tumor a wad of absorbent cotton, then poured onto the cotton hot water, for a period of twenty minutes, then injected in the outer edge of the carbuncle the solution of carbolic acid at fourteen different points, using a half syringe of the solution at each point. In some instances a portion of the injection oozed out of the small openings in the boggy portion. Then I threw into the boggy part several syringe of the solution, and dressed it with absorbent cotton and carbolized oil. The next morning Dr. Boylan injected at

two points where it looked like it was going to spread. The patient had but little suffering from this time; the sore healed rapidly; no morphine was given after the second day; and the scar was much smaller than I thought it could possibly be when I first saw the patient. The arm was useless for several weeks, but by the use of the battery he recovered complete use of it. From the condition of this patient when first seen, and the progress the disease was making, notwithstanding all the efforts that were made to check it, I think he would have died had not the disease been arrested by some potent remedy.

On the 16th day of April, 1885, I was called to see Mrs. H., aged seventy-nine. She had been sick fifteen days with a carbuncle on the back of her neck. It was over three inches in diameter, with a boggy spot in the center of over one and a half inches in diameter. There were eleven small openings or sinuses from which a thin pus was discharging. For the past three days she had had no rest or sleep, except what she obtained while under the influence of large doses of laudanum and Dover's powders. She was greatly exhausted by her suffering. I first applied the absorbent cotton and hot water, for twenty minutes, then injected with the carbolic solution at seven different points and about three-fourths of an inch from the edge of the boggy line, using half a syringe-ful at each injection. She went to sleep in thirty minutes and slept for three hours. She had but little pain after this treatment. For the next four days hot baths were given by applying the cotton as before stated, afterward dressing with carbolized oil. The sore rapidly healed, leaving a scar not one-half inch in diameter.

Dr. Boylan, of Milford Center, reports the following case treated by himself last May: Mr. H. T., aged thirty-five, a laborer, came to his office with a carbuncle on the back of his neck, which was three inches in diameter; his suffering had been terrible for twelve days; came for the purpose of having it lanced. The Doctor injected it with a solution of carbolic acid, in water, one to ten; applied cotton and a solution of carbolic acid, and requested him to return in a day or two; as he did not return, the Doctor supposed he had become dissatisfied and had applied to some other doctor. In a few days he saw him at work. On inquiry, the man said he had slept well the night after the injection; had gone to work the next morning, and had worked every day since. The sore was discharging a small quantity of healthy pus, and the induration was almost gone.

The above cases are sufficient to show the results of this plan of

treatment in the very old, in those who have been injured by excessive drinking, and in those of usual good habits and health. I could report many more, but this is sufficient. I will say that in no instance have I been disappointed.

In one case I put in two or three drops of pure acid ; a small black spot appeared at the place of injection the next day, and I was afraid a slough would form, but in a few days the color changed to normal.

In two cases of piles where I injected equal parts of carbolic acid and olive oil, using six to eight drops, I had a small slough of cellular tissue from the pile, but no serious results followed. Since then I have used a solution of one to ten or fifteen of water, and inject so as to distend the pile quite firmly. This cures with much less pain than the stronger solution.

From our experience with carbolic acid and oil, the oil does not reduce the strength of the acid. And as the weak solution of seven to one of oil and carbolic acid arrests the disease of carbuncle and cures piles, and is perfectly safe, I think we should not use the stronger for fear that in some cases it may cause a slough. In cases of chronic indurated ulcers I have found injections of carbolic acid solution of one to seven at the margin, or where the induration commences, to insure a rapid recovery. In snake or dog bites I believe this would be more effectual in arresting the poison than burning with acid or other substances, and not half so painful.

NOTES IN OBSTETRICS AND GYNECOLOGY FROM THE VIENNA CLINICS.

BY MARY J. FINLEY, M. D., MANSFIELD, OHIO.Read before the N. C. O. Med. Ass'n.

I suppose no well ordered Gynecologist of this favored land has ever yet practiced his art for two consecutive days without introducing a speculum and applying tincture of iodine to the cervix. Naturally enough, they must do the same thing in Vienna ; but if a student enters one of the clinics there, burning with high hopes of seeing something new, and witnesses this familiar routine on the first half-dozen patients, he begins to wonder vaguely what he crossed the ocean for. It may be worth while, however, to notice even how this simple operation is performed. Cylindrical specula are almost exclusively used, a preference with some being now given to milk glass, tapering to the inner extremity rather more than the Ferguson model. The speculum is introduced with the tip backward and pushed gently in the direction of the cervix without rotating. When applications are made to the cervix alone the speculum, pressed closely against it, is used to protect the vagina, and all superfluous fluid is taken up with cotton before its removal. When it is desired to apply remedies to the entire vagina, about an ounce of the selected remedy, if a liquid, is poured in the speculum and thoroughly applied to every part with a cotton probang, as the speculum is slowly withdrawn. By turning the instrument downward, just before its inner end escapes the introitus vaginæ, the surplus fluid is caught in a pus pan. The duck-bill, (Sims) the bivalve and trivalve specula are also used, but only occasionally, and to meet certain exigencies. The cylindrical is the standard instrument. While I am by no means ready to abandon the use of my favorite bivalve in the treatment of the cervix, I am thoroughly convinced of the superiority of the cylindrical in making applications to the vagina.

Prof. Rokitansky, in his clinics in the Maria Theresia hospital, uses solutions of pyroligneous acid of varying strength to the cervix and vagina in cervicitis and vaginitis. Sulphate of copper in solution is another favorite of his. In intractable cases of vaginitis, he fills the vagina with powdered acetate of lead, packing it in with a spatula as the speculum is gradually withdrawn. This is allowed to remain undisturbed for three or four days. It is then loosened and removed by the finger, and a stream of water from a douche, and comes away in small lumps. Cases which had resisted all other means of treatment, improved

rapidly after this proceeding. In rare cases, where, after advancing to a certain extent, improvement ceased, this treatment was repeated with good results. In this clinic intra-uterine treatment is given to patients who are allowed to return to their homes, with no other precaution than an hour's rest on the benches of the ante-room. I never saw any evil results from it. It is done cautiously but thoroughly. Tincture of iodine is injected by the intra-uterine syringe of Gustav Braun. The barrel of this instrument is of glass, graduated like a hypodermic syringe, so that the operator can see exactly how much he is injecting. It holds only half a drachm. The nozzle is made with the uterine curve, and long enough to reach to the fundus while the barrel remains outside the vulva. The end of the nozzle is closed, and the fluid escapes by a small opening, scarcely larger than a pin hole, in one side, so that the remedy used can only escape in drops, and is instilled rather than injected. This instrument is now made in this country by Tiemann, of New York.

Solid nitrate of silver is introduced by means of the carrier of Chiara; a stout sound of hard rubber, having a hollow end of fine silver or platinum, $1\frac{1}{2}$ inches long, perforated by small oval openings. This end is unscrewed from the sound and filled with the nitrate, preferably a stick made just to fit it. It is then replaced and carried up to the fundus. The sound is moved from side to side, so as to insure an application to all parts of the lining membrane, and allowed to remain in the cavity some seconds, or some minutes, as it is desired the application shall be more or less thorough. With this instrument it is doubtful if the solid caustic comes in contact with the endometrium at all. A solution of nitrate of silver in the secretions of the cavity of the uterus is what is actually applied to its lining membrane. This, it will be perceived, is a much less heroic proceeding than the introduction of the bare stick, of which a piece is broken off and left in the cavity, as so strongly advocated by Byford in this country, and Courty in Europe. The application ordinarily was not painful, and was never followed by untoward results.

A few years ago, in Philadelphia, by far the most common and frequently performed operation in gynecology was Emmet's operation on the cervix. It was "all the rage." However, it may be out of style by this time. It is a fact that in our great medical centers fashions change in medicine and surgery about as frequently as they do in bonnets, and the changes are often just about as needful and important. In medicine we call this progress, while in millinery, alas, it is named frivolity. The

remedy which one year is in everybody's mouth (literally as far as the patients are concerned), which fills the journals with reports of its wonderful effects and ever widening field of application, is next year allowed to rest quietly on the shelves of the druggist, and the modification of some surgical procedure, which is one year heralded as a great discovery, may be the next silently abandoned even by its originator.

After I had been in the Gynecologic clinics of Vienna a week or two without having seen or heard of an Emmet's operation, I modestly asked one of the Professors for his opinion of it. He replied that he considered it an excellent operation *where it was indicated*. He had performed it *once*. This was the only case he had ever seen which required it. Hypertrophy of the lips with erosion (the condition which Emmet declares calls for his operation), if not extensive, is treated with various applications to bring about involution and healing, and the accompanying catarrh of the uterus is alleviated by intra-uterine medication; if extensive or intractable, amputation of the cervix is performed by one of the many operations devised for the purpose.

When the cervix is the seat of malignant disease, amputation by cautery is preferred to a cutting operation. The galvano-cautery wire used in the ecraseur is employed when the vaginal portion only is to be removed. This instrument has the same disadvantage as the ordinary chain or wire ecraseur, a tendency to draw into its grasp tissue far beyond the desired point. In one case in the clinic of Prof. Rokitansky, where it was used to remove a carcinomatous cervix, the posterior cul-de-sac and pouch of Douglas were drawn into it, and an opening an inch in diameter made into the peritoneal cavity. No bad results followed this alarming accident. An epiploon which protruded was returned, the parts plentifully dusted with iodoform, and the patient put to bed. In two weeks she left the hospital apparently perfectly well. Where cancerous disease had extended from the vaginal to the supra-vaginal portion of the cervix, a conical amputation was made by Paquelin's thermo-cautery. With this instrument I have seen a mass of cancerous tissue, which had extended up to the body of the uterus, scooped out in a perfect cone, leaving the shell of healthy tissue intact. This makes a very attractive operation, in many cases unattended by loss of blood, but it is treacherous. In two cases I saw it followed by most alarming hemorrhage. In the first the hemorrhage was secondary, following the sloughing, and recurring again and again until the patient was completely blanched before it was finally controlled.

In the other case it occurred during the operation and placed the life of the patient in imminent jeopardy.

The galvano-cautery wire ecraseur is used very satisfactorily on intra-uterine fibroids when they protrude into the cavity of the womb, even when there is no well defined pedicle. The surgeon here, by the way, is not his own electrician and does not keep his own battery. When he proposes to use electricity, the electrician comes with his battery, and operates it, while the surgeon need only concern himself with its immediate application.

I was much pleased with the operation of anterior colporrhaphy as it is here performed. The portion of anterior vaginal wall denuded is lozenge shaped, and extends from the cervix to the urethra. Four pairs of bullet forceps are used in the operation; one pair catches the membrane immediately under the opening of the urethra, a second pair that just adjoining the anterior lip of the cervix, and the other two are caught in points just opposite to each other midway between the urethral orifice and cervix, and as far apart as the membrane is to be removed. When these are all properly held the surface to be denuded is put upon the stretch, lies conveniently to the hand of the operator, and the denudation can be quickly and painlessly accomplished, without introducing the finger in the bladder. The operation was always performed without an anesthetic. The stiches near the cervix and the urethra are imbedded throughout their course; in the central and widest part, only part way imbedded. Posterior colporrhaphy is here, as with us, rarely performed without an accompanying perineorrhaphy. For the latter operation silk sutures are used. They are introduced with a long straight needle, which looks very much like the darning needle of domestic use, and are not imbedded in their entire course.

That which most impresses a student here is the uniform success of operations, and the rapid recovery of patients from the most serious surgical procedures. Operations are not performed under the spray, but strict antisepsis is observed in every detail in the preparation for, during and after an operation. Corrosive sublimate in solution, iodoform in powder, in pencils and prepared gauze, are just now the favorite antiseptics in Vienna. Iodoform is not quite so freely used in gynecology as in general surgery and obstetrics. In some of the surgical clinics every wound is literally deluged with iodoform. There are seldom unfavorable symptoms observed here from the free use of this drug. Occasionally there is a slight yellowish discoloration of the urine, an odor

of iodoform on the breath, and slight taste of it in the mouth. The most severe symptoms observed are headache, nausea and vomiting, which soon pass away. In two cases, which were believed to have died from iodoform poisoning during the early use of the drug, these symptoms merged into those of acute cerebral meningitis. The lesions of that disease were not found at the autopsy.

Antiseptic midwifery began in Vienna about eighteen years ago. Previous to that time the mortality from puerperal fever had been frightful. For the two years preceding its introduction, thirteen and one-half per cent. of all cases confined died from this disease; for the year following its introduction the mortality fell to one and one fourth per cent. It is now considerably below one per cent. No physician or student makes an examination of a woman in labor without first washing the hands in some disinfectant solution. Before and after labor the vagina is washed out with carbolyzed water or a solution of corrosive sublimate 1-2000 to 1-5000. Immediately after the labor the vagina and perineum are carefully examined. Lacerations of the perineum, however slight, are immediately operated on. If mere ruptures of the fourchette, they are drawn together by serrefines. If lateral incisions have been made, these are united. All open surfaces are thickly dusted with iodoform. Should there be any tear of the cervix, pencils of iodoform are introduced. During the lying in should the temperature run up suspiciously, with or without offensive lochia, the uterus itself is washed out with the sublimate solution, care being taken that the water has free exit from the cervix. If the lochia are persistently offensive, the iodoform pencils, which contain about seventy-five per cent. of iodoform, are placed in the uterine cavity. As soon as the baby is born its eyes are washed off with a saturated solution of boracic acid, if possible before it opens them. It is claimed that this prevents ophthalmia neonatorum which was formerly very prevalent here.

Perineal lacerations are rare in the Vienna clinics. During the labor the perineum is protected rather than supported. As soon as the head begins to put the perineum on the stretch, the woman is turned on her left side and the buttocks brought to the edge of the right side of the bed, as she lies across it, with her legs well flexed. The right knee is then raised and supported by a nurse in such a way as to widely separate the thighs. The midwife sits on the side of the bed at the back of the patient, with the left hand passed over the right thigh of the patient, the fingers in contact with the advancing head, which, during

a pain, is kept well pressed upward against the symphysis, while the open palm of the right hand over the buttocks pushes forward and relaxes the entire perineal tissues without making pressure upon the perineum itself. In this way the amount of force expended upon the perineum by each pain is largely under the control of the midwife, and a gradual dilatation is secured. If it become apparent that the perineum will not stretch to the required extent, and the whitening of the anterior margin shows that a tear is imminent, lateral incisions are made through the lower third of the labia minora, on one or both sides. This operation, if performed in time, rarely fails to prevent laceration.

The forceps commonly in use in the clinics, and recommended to the students, is the well known J. Y. Simpson instrument, made perhaps a little heavier than the same instrument as manufactured in our country. Two modifications of this instrument, which have been recently made by former assistants in the clinics of Braun and Spaeth, have deservedly attracted a great deal of attention. These modifications are designed to enable the operator to make traction in the line of the pelvic axis when the forceps is applied at or above the brim, to make it possible to change the direction of the traction with the changing curve of the pelvic axis from the inlet to the outlet. The principle is the same as in the axis traction forceps of Tarnier. All these instruments attempt to meet the difficulty they are designed to overcome, by having what is practically two pairs of handles to the blades; one pair immovably attached to or directly continuous with them, the other pair attached by a movable joint. In the instrument as modified by Breus, called by him *beckenrein gangzangen* (pelvic inlet forceps) the handles proper are attached at the lower angle of the fenestrum by a joint which allows of free motion backwards and forwards. The upper border of the fenestrum is prolonged parallel with the shaft to the point where the latter bends in to the lock, and there turns sharply upward in a spur about two inches long, which terminates in an eye. When the blades are locked a pin is slipped through from one eye to the other, joining them closely together. The modifications of Felsenreich are arranged as attachments which can be removed, leaving the instrument for application in the pelvic cavity or at the outlet, the ordinary Simpson's forceps. These attachments consist of a compression thumbscrew in a slot in the end of the handles, designed to insure the continuous grasp of the blades upon the head, and of traction rods which fasten by a flat button in perforations in the blades at the

lower angle of the fenestrum, at the same point where the joint is found in the instrument of Breus. The rods are curved downward and inward to meet in a hard rubber handle. The rods and handle to which they are attached resemble in general features those of the Tarnier instrument. The forceps of Breus appears to be the favorite in Vienna for application to the high lying head; but the instrument of Felsenreich has a better chance of introduction in general practice from the fact that it does not necessitate the carrying of a second forceps for ordinary use. Each of these instruments has its advocates and admirers in Vienna. It is claimed that both are decided improvements on all previous models designed for high application, but it is generally conceded that the perfect forceps for use in all cases has not yet been invented.

ICE IN THE SICK ROOM.—A correspondent of the *National Druggist* thus writes:

The writer's son suffered with typhoid fever during the heated term of last summer, when the temperature of the room often rose to 90° or 95°, and the patient's temperature ran up to 105° F. and over.

A number of tubs were placed in the room and kept filled with ice, and the doors kept closed. The temperature of the room sank to 80° or less, an average of 12 or 15° below the temperature of the other rooms in the house, and the cooler atmosphere not only added to the comfort of the patient, but aided in keeping down the body-temperature, and materially contributed to a final recovery.

We would strongly urge the use of ice in the room as a measure of comfort and luxury for all who are confined to their beds during hot summer days.

NOT A DOCTOR.—Young Wife—"There is a gentleman in the parlor, dear, who wishes to see you."

He—"Do you know who it is?"

Young Wife—"You must forgive me, my dear, but that cough of yours has worried me so of late, and you take such poor care of your health, and—and O, if I were to loose you, my darling!" (Bursts into tears.)

He—"There, there, dear. Your fondness for me has inspired foolish and unnecessary fears. I'm all right; you musn't be alarmed. But I'll see the physician, of course, just to satisfy you. Is it Dr. Pellett?"

Young Wife—"N-no, it is not a doctor; it's a—a—life insurance agent."

TREATMENT OF FLESH WOUNDS.

BY H. D. TAGGART, M. D., AKRON, O.

It is so common to meet with wounds more or less extensive which, owing to misapplied principles or no principles, are not doing well, that I am prompted to give my views respecting the management of these injuries. Happily for the surgeon, our patients are, as a rule, slow to detect minor errors in the dressing of wounds; they will patiently nurse a fetid, sloughing member for days and weeks, never suspecting that it might have been otherwise.

A very few principles well understood and judiciously used will make our treatment of incised and lacerated wounds in every way satisfactory to our ourselves and our patients.

The sedative effect of watery lotions, independent of any medicament contained, should be kept in mind. The constantly wet bandage, with the paralyzing effects of carbolic acid superadded, is every day working great mischief.

The germ hunter must have some kind of germicide, so he will select an agent capable of working great havoc to these much abused creatures, forgetting the wound; it may be growing still larger, its edges melting away in a sea of pus. Is he not killing the bacterium? Let us keep our wounds decently clean, and use sedative, stimulant, antiseptic and detergent medicines only, in the order indicated by the *conditions* met with. This I call the rational plan; it must always succeed.

Most wounds met with in every-day practice, accidental and those made by the surgeon, require wet dressing for a greater or less period. This should possess several positive qualities; it need not be strongly germicide, but it should be positively antiseptic. It will be antiseptic in a degree, if liberally used, it matters little what watery solution be employed, but when you add twelve and one-half per cent. of glycerine to your lotion, the dressings never become dry and leathery, penning up the discharges; now the lotion is becoming positively antiseptic, because it insures drainage.

But here is the one article which, of all others known to me, is necessary to make the lotion perfect, chloral hydrate. This is my prescription :

R Chloral hydrate, ... ʒj.
 Glycerinæ, ... ʒj.
 Aq. font. vel. dest., q.s. ad . . ʒviiij.

This lotion will be found to be of proper strength for fresh wounds; if made stronger, it will cause smarting, but will not act as a caustic.

Chloral solution is positively stimulant and antiseptic locally, and not sedative or anesthetic as many suppose. It is cheap, clean, and above all, reliable. No wound of external soft parts can give forth any fetor if the above combination be used.

From the first, the flesh will take on a beautiful pink color, and until the parts are healed the only odor encountered will be that of clean, raw flesh.

Much more might be said, but may be I have already presumed too far.

THE WONDERS OF AN EGG.—The *Popular Science News* says that Mr. Matthieu Williams, in one of his lectures says: "Every one who eats his matutinal egg, eats a sermon and a miracle. Inside of that smooth, symmetrical, beautiful shell lurks a question which has been the Troy town for all the philosophers and scientists since Adam. Armed with the engines of war—the microscope, the scales, the offensive weapons of chemistry and reason—they have probed and weighed and experimented; and still the question is unsolved, the citadel unsacked. Professor Bokorny can tell you that albumen is composed of so many molecules of carbon and nitrogen and hydrogen, and can persuade you of the difference between active and passive albumen, and can show by wonderfully delicate experiments what the aldehydes have to do in the separation of gold, from his complicated solutions; but he can't tell you why from one egg comes a 'little rid hin,' and from another a bantam. You leave your little silver spoon an hour in your egg-cup, and it is coated with a compound of sulphur. Why is that sulphur there? Wonderful, that evolution should provide for the bones of the future hen! There is phosphorus also in that little microcosm; and the oxygen of the air, passing through the shell, unites with it, and the acid dissolves the shell, thus making good strong bones for the chick, and at the same time thinning the prison-walls. Chemists know a good deal now about albumen; and if they cannot tell us why life differentiates itself therein and thereby, they can tell you how not to spoil your breakfast."

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Thermometer, indestructible index.....	\$ 2.25	\$ 2.50
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Landis' modified Davis' obstetric forceps.....	6.00	8.00
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Hale's (or Sawyer's) short forceps.....	5.25	6.50
Universal Hard Rubber Syringe, 5 pipes.....	3.00	4.50
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Fahnestock's tonsilotome, finest.....	6.00	12.00
10 vial, genuine morocco pocket case.....	2.35	4.00
Amputating and minor operating case.....	19.50	27.00
“ “ trephining case.....	29.60	40.00
Hypodermic Syringe, ordinary.....	2.00	3.00
“ “ finest; glass and hard rubber.....	2.75	4.00
Aspirator, and stomach pump (a perfect instrument).....	19.00	27.00
“ French style.....	11.50	15.00
Post-mortem case.....	10.75	12.00

The above prices include postage, where instruments can be sent by mail; otherwise they will be sent by express, at expense of recipient.

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IN DYSPEPSIA, CONSTIPATION, INDIGESTION, HEADACHE, &c.

The lining membrane of the stomach when in a normal condition contains cells filled with the gastric juice, in which phosphoric acid combined with lime, iron, potash, etc., is an important active principle; this is necessary to a perfect digestion. If the stomach is not supplied with the necessary gastric juice to incite or promote digestion, dyspepsia will follow with all its train of incident diseases. The only known acid which can be taken into the stomach to promote digestion, without injury, is phosphoric acid combined with lime, potash, iron, etc., *i. e.* Horsford's Acid Phosphate, which is hereby offered to the public.

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We have received a large number of letters from physicians of the highest standing, in all parts of the country, relating their experience with the Acid Phosphate, and speaking of it in high terms of commendation.

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MEDICINE.

THE TRUTH ABOUT ALCOHOL.—The temperance movement is one of the most notable phenomena of our time. In every town and village of our country total abstinence societies exist and flourish. We understand that in the New Parliament the teetotal party number forty, and that the advocates of local option have received a large accession of strength. It is a most significant fact that all the working men's representatives in the House of Commons are total abstainers. To those who read this fact aright, it speaks not merely of hopeful augury for the future, but of the grim tragedy of the past. Working men alone have felt the full curse of intemperance, which has been the chief cause of their poverty and degradation; hence, no doubt, the attitude of their representatives.

The medical profession has a heavy responsibility in this matter, which they are not disposed to avoid, and which, moreover, they cannot avoid if they would. To a large extent, they are the court of appeal upon this question. They are familiar with scientific teaching upon alcohol, they see daily the fruits of intemperance, and they are ever watching the effects of alcohol both in health and in disease. The public look to us for guidance and instruction; our lightest word has often more weight than the most fervid oratory of temperance lectures; and our attitude, whether negative or positive, has a powerful and far-reaching influence. On all these grounds, it is imperative upon the profession that their opinions on the alcohol question should be well weighed, firmly founded in unassailable truth, and free alike from the approach of prejudice and of passion. On the one hand, we cannot be indifferent to a great moral movement, advocated undoubtedly, in many cases, from the purest patriotism and the highest Christian charity; nor, on the other hand, can we sanction the employment, even for the noblest ends, of a single questionable statement or argument, nor sacrifice a vestige of truth even at the holiest of shrines. No cause ever derived lasting benefit from error. Truth is great and will prevail, not merely because it is right that it should prevail, but because in the nature of things it must prevail. The advocates of temperance, who not rarely have more zeal than knowledge, would do well, therefore, to remember, that any unauthorized or questionable statement about the physiological action or therapeutic application of alcohol, is a serious injury to their cause, and tends to alienate from them the sympathies of the cultivated and reflective classes, whose opinion in the long run determines national opinion. It is, for example,

SELECTIONS.

... temperance platforms that alcohol is a poison. ... definition of terms. A poison is usually defined in small quantity injures health or destroys life. ... true that an individual can poison himself with ... alcoholic poisoning are unhappily all too common ; ... sulfuric acid or with chlorate of potash is not uncommon. ... streams of styling these substances poisons, as popularly. If the quantity necessary to produce the fatal effect ... acid has a much better claim to the title of poison ... inasmuch as a dose of a teaspoonful has been known to destroy it requires many times this quantity of alcohol to produce a poisonous effect.

... frequently asserted from temperance platforms that moderate drinking in all degrees and in every instance is injurious to health ; ... even denied that alcohol possesses any virtue as a stimulant. Such views are opposed to all medical evidence ; and it is regretted that they should be rashly propounded, to the injury of the cause which their advocates are anxious to serve. Enthusiasm for a high object is admirable, but when truth is violated, she will punish the transgressor for her *læsa majestas*.

What, then, is the truth about alcohol ? We think it admits of being stated with certainty and precision in its broad outlines, and that the minute details of the controversy hardly affect the main contention. We may conclusively prove, in the first place, that alcohol is not a necessary food, and that the most perfect physical and intellectual vigor is compatible with rigid total abstinence. We may go a step further, and confidently assert that people in perfect health are as a rule better without alcohol. The question may almost be regarded as finally settled, when a word of Sir Henry Thompson's eminence speaks as follows : " I am of opinion that the habitual use of wine, beer, or spirits, is a dietetic error, not for nineteen persons out of twenty. In other words, the great majority of the people, at any age or of either sex, will enjoy better health, both of body and mind, and will live longer, without any alcoholic drinks whatever, than with habitual indulgence in their use, even although such use be what is popularly understood as moderate." (*Food and Feeding*, page 98.) In view of the great mass of evidence to this effect, we must own to feelings of surprise and disappointment at finding Sir William Roberts, in his recent work on *Dietetics and Dyspepsia*, throw out a somewhat obscure hint that, although a non-alcoholic regimen may be harmless

to the individual, it may possibly affect the race injuriously in the course of two or more generations. We are most sceptical of the existence of any evidence to warrant this surmise. The evils of intemperance are manifest; the evils of total abstinence are unproved and improbable. The excellent health enjoyed by the great and increasing army of teetotallers, the returns of insurance and benefit societies, the example of abstaining nations, seem to us proof positive that total abstinence is at least harmless and safe. Alcohol may be accorded a place as a luxury; it certainly has a definite value as a medicine, but we think it most desirable, in the interest alike of truth and of national morality, that the medical profession should authoritatively and unambiguously declare that it is in no sense a necessity. It is on this point that the controversy really hinges, and we think the evidence regarding it is perfectly conclusive.

Secondly, we think we can affirm with equal confidence that, while alcohol possesses a certain and considerable medical value, its therapeutic range is gradually becoming more circumscribed. Time was, when it was the first suggestion and the last resort of the distressed practitioner. We are wiser now, less confident of its virtues, less ready to trust so potent a weapon to hands that may employ it in self-destruction. There are hospitals which have reduced their spirit-bills to one-half or one-fourth their former amount, with at least no obvious injury to their inmates. There are diseases, once uniformly treated with alcohol, which we now know to run at least as favorable a course when it is withheld. Yet we think we speak the almost unanimous mind of the profession, when we say there are cases which hardly any well-trained medical man could treat without alcohol and keep his conscience clear. In pneumonia, for example, the benefit from it seems decisive. In typhus and typhoid fever, there are crises where the free use of alcohol seems literally to snatch the patient from the jaws of death. On the other hand, we deprecate most strongly the routine practice of deluging all such cases with stimulants, and urge that each case should be separately judged in view of its symptoms, alcohol being prescribed with the same deliberation and circumspection as opium or aconite. When we leave the acute pyrexial diseases, we are on less secure ground regarding the action of alcohol. It seems of value in many cases of phthisis, and especially in soothing the last stages of the malady; but the form of stimulant needs careful selection, and, not rarely, it is better omitted altogether.

The above cases will not seriously tax the judgment of the practitioner; but, with regard to patients suffering from simple debility, anor-

exia, etc., the decision regarding the use of alcohol is most anxious and difficult. It is beyond question that such cases often benefit decidedly by a little good spirit, or a glass of generous port or burgundy. Appetite and digestion are often thereby promoted, and sleep is sometimes induced to return. Yet these cases are just the chosen material of which inebriates are made, and the relief of dyspepsia or insomnia would be dearly purchased by running the gauntlet of intemperance. Everything depends upon the patient; and our course of action must be guided not merely by the nature of his ailments, but upon our estimate of his strength of will.

It is perverse to assert that every moderate drinker is a drunkard *in posse*, or that we must withhold alcohol in every case where there is the faintest possibility of it being abused; but the trained observer will learn to distinguish those cases where the risk of excess is so patent, as to outweigh the prospective advantage which might reasonably be hoped from this line of treatment. Two rules may be laid down with confidence. Alcohol should be rigidly prohibited in hysteria and in all forms of quasi-hysterical debility, and it should be more strictly withheld in every case where there is an undoubted hereditary tendency to intemperance. A medical man may feel disposed to take the ground that he is accountable only for the conduct of the existing malady, and has no responsibility for the after-consequences of his treatment. With much respect for those who differ from us on this point, but with great earnestness, we submit that to pull a patient through the crisis of pneumonia or typhus, unless under urgent circumstances, at the terrible cost of developing a clearly marked hereditary tendency to intemperance, is not calculated either to advance the honor of the medical profession or the best interests of humanity.

We urge the profession to realize their great responsibility and their immense influence upon this question. Their views should be deeply pondered, their words weighty and well-spoken. They must hold the balance between selfish indifferentism, and a zeal which not seldom borders on fanaticism. They must earnestly desire to know the truth, and proclaim it through good and through evil report. They must refuse to be coerced into abating one jot of their deliberate convictions at the bidding of any organism; but they will, we think, learn to look with a more and more favorable eye upon a great moral movement which will not in all cases gain their adhesion, but which has a powerful claim upon their sympathy and respect.—*Brit. Med. Jour.*

INDICATIONS FOR ARSENIC IN MALARIA.—Dr. James Craig, of Llandudno, writes: The antiperiodic properties of arsenic are well known, but, so far as I am aware, no one has pointed out any symptom usually found in the cases in which it is successful which distinguishes them from those, perhaps the greater number, in which it fails to prevent a recurrence of the malarial symptoms. The cases in which arsenic is beneficial have one symptom in common, viz.; at one period of the twenty-four hours, sometimes several times daily, but most frequently only in the morning after rising, the patient experiences a sensation of coldness, most marked in the hands and feet, and combined with this chilliness there is a decided fall in the temperature. In India I have frequently seen the temperature during one of these seizures under 96° F. And in this country I have on several occasions seen the temperature fall to 94.5° . The low temperature continues for about half an hour, and then gradually rises to about 97.8° , which in these cases is the usual average temperature. The severity of the symptoms experienced during the seizures varies in different cases, and also on different days. Some days there is no attack, on other days only a very mild one. These seizures of low temperature often continue for months after the last attack of ague, and quinine has little influence on them; but small doses of arsenic quickly, "often in nine or ten days," prevent, or at least modify them, and if the arsenic is persevered in for a long period (with occasional intermissions), and the patient is not again exposed to malarial poison, it prevents their recurrence, and also prevents a return of intermittent fever. The attack of chilliness is not the cold stage of an aguish attack. (Although I find that if the temperature is taken at the commencement of the cold stage of an aguish attack, there is, at least in many cases, an actual fall in the temperature.) But in these attacks of chilliness the feelings experienced by the patient differ from those felt during the cold stage of ague; and as these patients usually have considerable experience of both symptoms, they can predict whether or not the chilliness will be followed by an attack of ague. Examination shows that although the temperature is so much reduced in the attacks of chilliness which are not followed by the usual symptoms of intermittent fever, still there is never so much prostration or nervous disturbance as there is in the cold stage of an attack of ague. I have found arsenic equally useful in attacks of hemoglobinuria of malarial origin when accompanied with similar seizures of low temperature. The seizures of low temperature are not abortive attacks of homoglobinuria; and when occurring in persons suffering from this disease are distinguished from the

abortive attacks by the greater lowering of temperature, by not being accompanied with disintegration of the blood-cells, nor by draining of the coloring matter out of the red blood corpuscles—both of which changes I have seen in a drop of blood taken from the finger during an attack of abortive hemoglobinura.—*Lancet*.

DOUCHES AND LOTIONS.—Under the title of Douches and Lotions for the throat and nose, Dr. H. McNaughton Jones writes thus practically in the *Practitioner*:

To thoroughly wash the pharynx with a gargle in cases of follicular pharyngitis, tonsillar hypertrophy, and general pharyngeal relaxation, is frequently a most essential adjunct to more direct applications to the nose and nasopharynx. To get a patient to do this properly he should be made to lie down on his back, and keep the head low when gargling the throat. With a little education and practice he can learn how to force the fluid up behind the soft palate or eject it from the nostrils. The use of a nasal spray or douche is a much more satisfactory method of insufflating the nasal passages than the plan sometimes adopted of directing the patient to sniff up some medicated fluid. A small portable insufflator after the plan of Sass, which can be carried in the pocket and contains so much of the fluid or powder required, can be had for those who are traveling. I have never found any serious effects follow the use of the syphon nasal douche. I have occasionally had to abandon it in consequence of headache, frontal-ache, giddiness and ear-ache, resulting. This occurred only when permitting the stream to pass through from one nostril to the other by the usual method of holding the head forward. But I have found that such symptoms were more frequently due to imprudent and improper application of the douche, for they have disappeared when the following precautions were adopted: (1) The regulation of the force of the stream, the patient holding the vessel of fluid in the hand, raising or lowering it according as it is wished to increase or lessen the strength of the douche; (2) the maintenance of a proper temperature of the fluid (about 100°), the colder the douche the greater the risk of unpleasant results; (3) the avoidance of strong saline solutions; such concentrated fluids entering the Eustachian orifice may cause intra-tympanic inflammatory disturbances. The mouth should be kept slightly open during the act of douching, and for the moment or two it is better to direct the patient to suspend his breathing. Frequently it is not necessary to do more than allow the stream to pass from a height a little above the head into either nostril.

I prefer to use all weak astringent and disinfectant washes by means of the nasal spray, such as alum, tannic acid, sulpho-carbolate of zinc, chlorinated soda (ʒii liquor. sodæ chlor. ad ʒviii), chloride of zinc (gr. ii ad ʒi), carbolic acid (gr. ii ad ʒi), bichloride of mercury (1-2000), hazeline with infusion of matico (ʒi in ʒvii), cocaine (with the special cocaine spray.) The more concentrated solution of glycerine and perchloride of iron (grs. xx-xxx ad ʒi); the combination of aldehyde (2 pts.), and carbolic acid (1 pt.), glycerine (5 pts.), iodol or iodoform in ether (grs. xx-xxx ad ʒi); chromic acid (grs. x-xx ad ʒi), nitrate of silver (grs. x-xx ad ʒi) are best applied with the nasal probe and cotton-wool. The nares should be wiped clean with absorbent wool before any of these solutions are used. Should severe smarting follow the application and last any length of time, a warm alkaline stream should be passed through the nostrils. The powders for insufflation I find of most service in catarrhal conditions are those of iodoform (deodorized with fresh coffee, coumarine or vanilline), tannic acid, catechu, oxychloride of bismuth, and in tonsillar and throat congestions, guaiacum. The quantity of each may be regulated at from gr. ss to gr. i for each insufflation, powdered starch or lycopodium making an admirable basis. Fatty preparations serve in ulcerative states. I do not much care for greasy applications to the nasal membrane, but we can well apply in this manner iodoform or iodol, bismuth, belladonna, morphia, bichloride of mercury, the oxides of mercury, iodide of potassium, oxide of zinc, cocaine, the best medium of suspension being one part of vaseline and two parts of lard to four parts of lanolin. There can be no doubt that lanolin, diluted with lard, geoline, or vaseline, makes a capital absorbent basis for ointments. Iodol is the best substitute for iodoform, being quite devoid of its unpleasant odor and possessing all its properties without any of its toxic effects. I give this opinion of iodol from personal use of the drug.—*Amer. Prac. and News.*

THE RIGHTS OF SANITATION.—The time has arrived in this country for the stricter enforcement of a considerable body of miscellaneous sanitary law, and for the enactment and execution of the kind. This special law, like all other law, has to struggle against ignorance, selfishness, perverseness and wickedness. Underlying it will be found the well defined principles of criminal law. If a man kills his neighbor the criminal law inflicts the same penalty on him whether he does the killing with poison, with a knife, with a club, or with a gun; but if he does the killing by means of beer poisoned with “multum,” by means of a back-

house in the basement of a building let to a tenant, by means of milk containing germs of scarlet fever, by means of pork containing trichinæ, by means of tea containing a "bloom" of black lead, by means of wall-paper colored with arsenical pigments, by means of wine "doctorhd" to taste by admixture of "plasterage," by means of a child sent to school bearing the contagion of deadly disease, by means of ships so crowded between decks with emigrants that each person has less than thirty cubic feet of air space, by means of a theatre so constructed that even in case of *alarm* of fire a large percentage of the inmates are sure to be trampled to death, by means of a hospital built in defiance of every hygienic law as a monument to civic ignorance and pride, by means of a deadly drug administered by pretentious quackery, then the enactors of statutes consider their constituencies and the elective magistrates look over their shoulder and out of the windows to observe the direction of the popular breeze. While it is very evident that public instruction must keep pace with law, it is also evident that malefactors who snap their fingers at preaching and teaching, can be reached only by the infliction of dreaded penalties. The world can never be reformed by moral suasion alone. Immanuel Kant, the most vigorous ethical soul in modern times, says: "When a man has made worm of himself, he cannot complain if he is trampled under foot." If tenants whose humble homes have been visited by the angel of death, the sanitary delinquency of a landlord, instead of passively submitting to their fate would mob him and throw him into the stagnant pool under the building that he has refused to drain, or into the reeking cess-pool that he has refused to clean, it would do more good than the best hygienic track on sewer-gas ever written. If a thousand emigrants after escaping from the foul dungeons of an ocean steamer, would turn around and abate the nuisance by burning it up, and there is some color of law for such a proceeding, it would do more public good than any other of Congress, winked at by morally stupid official. If the proprietor of an "Orange County Dairy," known to be distributing milk from premises infected with small-pox, scarlatina, diphtheria, or typhoid fever, along a street where crape on many a door already indicates the sad fruits of his deadly trade, were set upon by an outraged community and hung on the nearest lamp-post, instead of being arraigned before a magistrate and *perhaps* fined ten dollars and cost, the summary proceeding would absolutely infuse a healthy ethical vigor into the makers and administrators of law. The public need to be told again, in the trenchant language of Kant: "*Let not your rights be trampled under foot by others unpunished.*" As long as we have a "stump-tail" state of ethics, hygienic questions, in the community, too rotten and feeble to beget sanitary indignation, we shall have plenty of interested men to trample uncomplaining worms under foot.—O. W. WIGHT, of Detroit, in the *Sanitarian*.

GERMS AND PTOMAINES.—In concluding his paper before the French Academy of Medicine, Prof. Peter made the following remarks:—"M. Gauthier has shown that in the dead body, and even in the living, ptomaines are found; these alkaloids, ptomaines or leucomaines, are absolutely toxic; an auto-infection, characterized by hyperthermia, is the result. This theory rids us, at least for a time, of the tyranny of the microbes. If urea, which is an alkali, is constantly formed in our organism, why should there not also be formed an alkaloid in it? It is only a question of degree. Life is a contingent phenomenon; it is a serial of partial deaths. It may therefore be said that we carry in ourselves, while living, a portion of our own corpse, but we resist the work of auto-infection by two distinct mechanisms—the elimination of the toxic substance and its destruction by oxygen. We should no longer hesitate between the parasitic doctrines, which are shrouded in dark hypotheses, and this new doctrine, which is as luminous as it is precise, which explains the phenomena of normal and abnormal life."—*Lancet*.

BROMIDIA.—The following remedy is one which has been used for some time by my colleague (Dr. Proudfoot) and myself, and I give the results:

About eighteen months ago a friend of mine from America told me of the wonderful effects of a medicine, much used in the States, called Bromidia. According to the makers, it is composed of chloral hydrate, fifteen gr.; potassium bromide, fifteen gr.; extract of cannabis indica, one-eighth gr.; and extract of hyoscyamus, one-eighth gr. I obtained some, and have ordered it regularly for over a year; and have found it excellent in the pain of rheumatism, pneumonia, and cancer; also in the sleeplessness of scarlatina and alcoholism. It has never failed me in procuring sleep, without the disagreeable dreams and after-effects of opium. The dose is ʒss. to ʒj. every hour till sleep is procured. I have also found it of much service in cases of tonsillitis, used as a gargle with glycerine and carbolic acid.—*J. Lindsay Porteous, M. D., F. R. C. S., M. R. C. P., Ed., in Edinburgh Med. Journal*.

A SIMPLE REMEDY FOR CHRONIC DIARRHEA.—T. C. Smith, M. D., of Aurora, Indiana, highly recommends drachm doses, three or four times daily, of a saturated solution of common salt in cider vinegar in the treatment of chronic diarrhea.

A FEW FALLACIES.—Perhaps the formulation of a few popular fallacies may not be without interest to our readers at this time, even if they be indisposed to accept the statements without some qualification.

It is a fallacy to suppose :

That alcoholic drinks support physical strength during excessively hot weather.

That seasonable weather is ever unhealthy.

That men and women should eat the same kind and amount of food when their manner of life is entirely different.

That pie is really indigestible; or, in general, that the quality of indigestibility can be logically affirmed of any article of food absolutely and apart from a consideration of the digestive capacity of the particular stomach the powers of which are to be tested.

That disease, in any given case, consists simply in the group of symptoms complained of by the patient, or morbid signs detected by the physician.

POST-MORTEM TRANSFUSION OF ARSENIC.—It has been shown that arsenic injected into the stomach after death can pass to the liver and neighboring viscera, but it has been doubted that the processes of transfusion could carry arsenic so injected to the brain, and in general it has been assumed that the hydrogen sulphide produced during decomposition converts arsenic into insoluble sulphide, thus preventing transfusion.

F. S. Sutton has made injections of three grains of arsenious oxide into the stomach and rectum of dogs that had been killed by chloroform twenty-four hours previously. After burial during a time varying from three to one hundred and two days, arsenic could be detected in the liver, kidneys, and brain, and the longer the lapse of time the more arsenic was present in the brain. Scolosuboff's statement that arsenic is deposited in the brain only during life, and that the presence of arsenic in the brain is conclusive evidence that it was absorbed during life, is consequently untrustworthy.—*Medical Times*.

NEW SIGN OF DEATH.—M. Lessenne, at a meeting of the Societe Medicale d'Amiens, indicated a certain sign of death, simple and trustworthy. After pricking the skin with a needle, the puncture remains open, just as when a piece of leather is pricked. On the living body, even if the blood does not come to the surface, as would happen if the person were hysterical, the pin-prick closes at once, and does not leave the slightest trace.—*Brit. Med. Journal*.

That all morbid processes are necessarily destructive in their nature, and are never conservative. Disease in certain cases may be nature's method of righting a wrong or overcoming the effects of some disturbing agent. A certain portion of the clinical picture of a disease is therefore made up of evidences of reaction as well as of direct morbid action.

That, in the production of cholera infantum, the elevation of the atmospheric temperature plays the most important part, or furnishes the principal indication for treatment.

That a person is well who feels well, and that sickness consists in feeling sick.

That specifics can be said to exist in modern medicine.

That if an individual is sick, takes medicine, and recovers, there is any necessary connection established between the administration of the remedy and the happy result, or that the multiplication of such cases can do more than establish a probability of the remedy rendering service under conditions apparently analogous.

That if a patient has ever contracted syphilis, every morbid sign occurring later in life is necessarily due to this disease, and calls for the administration of the iodides.

That an insane patient must necessarily be a fit subject for removal from home; admitting at the same time that the percentage of recoveries in hospitals for the insane is much greater among mild and recent cases.

That the actual number of years of a man's life bears any direct relation to the conditions of the physical frame known as senile degeneration.

That typical hysteria can exist in a perfectly healthy patient, even though the essential lesion may not be discoverable by the pathologist.

That the conditions of modern life in our highest civilization are most favorable for the development of a large, healthy, and vigorous population.

That there is an essential distinction between sanitary and sanatory science.

That there are such things as "laws of health." — *Med. Times.*

CHRONIC STARVATION.—Upon whatever other points they may differ, authorities on dietetics agree that nitrogen is the most essential of all foods, and that a certain amount should be taken regularly. Diminution of the quantity of food, whether from inability to procure it, or a disinclination for it, generally means decrease or absence of

nitrogen. That this leads to dire results is a well established fact. Graily Hewitt, in an address on "Chronic Starvation and Delicate Females," before the British Medical Association, said "For the last ten years or more I have carefully inquired into the history of patients suffering with uterine and ovarian disease, or some affection incidental to child-bed, and I have found a continuous insufficiency of food, especially the nitrogenous, to have existed almost universally, so that I have naturally come to regard this chronic starvation as an important factor in disease."

The serious troubles arising from insufficient nourishment are also shown in a marked manner in the case of delicate females during gestation, a large proportion of whom are so enfeebled by the constantly recurring paroxysms of vomiting and the consequent diminution of food assimilation, that when the period of parturition arrives they are so reduced in strength as to be peculiarly susceptible to the attacks of disease incident to child-birth, and the offspring is ushered into the world puny and feeble, and especially liable to a complication of physical evils solely attributable to its starved and anemic condition.

Colden's Liquid Beef Tonic contains precisely the elements indicated by Mr. Hewitt as being so essential, combined with citrate of iron, cinchona, and simple aromatics, forming at once a palatable nutriment and reliable tonic, and its range of usefulness embraces all cases of debility of whatever origin. It has been in use fifteen years, and those who have used it most are most emphatic in its praise.—*Massachusetts Medical Journal, June, 1886.*

ERYTHEMA MULTIFORME.—At the last meeting of the French Academy of Medicine, Mr. Villemin made an interesting report concerning erythema. According to him it is not simply a local disease but a constitutional one. Under the general head *erytheme polymorphe*, he includes all the varieties which have been described by dermatologists, and regards the eruption as only one of its symptoms, while the pain in the fibrous tissues, and the swelling about the joints, have no connection with rheumatism, as has been supposed, but are manifestations of the same unique and independent malady.

This etiological identity is established by another fact, viz.: that the iodide of potassium is a specific for all forms of this malady, curing them invariably in from twenty-four to forty-eight hours. Relapses are of frequent occurrence, but they yield readily to this remedy.—*Gaillard's Med. Jour.*

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OBSTETRICS.

DIAGNOSIS OF RAPE IN CHILDREN.—Dr. Jerome Walker, of Brooklyn, reports twenty-one cases of rape or assault on little girls, in the *Arch. of Pediatrics*. His conclusions are as follows :

The presence of the hymen is not by itself a proof of virginity (as the law now defines virginity,—*i. e.*, the non-penetration at any time, even to the slightest extent, of the male organ into the privates of a female); that its absence is no proof of rape having been committed; that even where there is reason to believe it has existed the *carunculæ myrtiformes* are not always present. In cases of rape, lacerations and even severe contusions of the child's privates are comparatively rare, but that an abrasion or two, with connecting enlarged bloodvessels, especially on the inner side of the right vulvar surface, is not infrequent, probably because the penis impinges ordinarily more against the right than the left side.

It is well known to those who have many children as patients, that local injuries and disorders frequently improve, with or without treatment, quite rapidly; and so it happens that slight contusions in the privates of little girls, sufficient to be accepted by a jury as proofs of local injury, may disappear within twenty-four or forty-eight hours after their occurrence. One doctor, after an examination, may honestly report that he found no evidence of local injury, while the physician who saw the case but a few days previously may honestly take an opposite view.

As to the local appearances in cases of suspected rape Vogel truthfully says: "The funnel-shaped condition and marked tumidity of the external genitals so urgently insisted upon in works on medical jurisprudence as symptoms of rape having been committed, can only be of value after the frequent repetition of the act, which makes the condition well-marked. No permanent alteration of form, not even any decided contusion or tumefaction, can ever originate from the simple contact of glans penis with the hymen."

Apparently respectable men, as well as ordinary disreputable characters, outrage children; even fathers, step-fathers, and brothers will do it; and, probably in the large majority of instances, merely to satisfy sexual passion by onanism, rather than to effect complete connection, as would be the case if full-grown women were used. Children are used because more readily obtained and influenced, and because the risk of conception is not run, and because it is believed that the children will be so

influenced by threats and fear of exposure that they will not tell they were outraged. So strong is the popular belief that a man couldn't have connection with a female child without lacerating her, and that he wouldn't attempt to have, when lewd women are so plenty, that to say they can and they do is a revelation to many. We are to bear in mind, as physicians, that the size of a man does not necessarily determine the size of his instrument, and we not infrequently meet with men of good size who possess small instruments, hardly above the average of those of good-sized boys. "In a medico-legal point of view," says Woodman and Tidy's *Forensic Medicine and Toxicology*, "such a defense as size of the penis is worthless, because, although the disproportion may prevent complete or perfect intercourse, it does not prevent the attempt which is now justly held to be the essence of crime." According to Wharton and Stille's *Medical Jurisprudence*, while "a full and complete connection of an adult male with a child of twelve years is manifestly impossible, repeated efforts will produce such a dilatation of the parts as to render it finally practicable." An open or patulous condition of the vulva, but especially of the vaginal opening, has been pointed out in connection with a few of the twenty-one cases detailed in this article as suspicious, indicating repeated handling of the parts or the introduction of some foreign body.

In our experience the examination of a girl that has not been tampered with at all, or but slightly, reveals the two sides of the vulva very nearly approximated, even when the legs are separated. If there is no hymen, the vaginal opening is small, much smaller than would be anticipated even in a girl of twelve or thirteen years of age, and the introduction of the tip of the index finger and sometimes of the little finger is attended by great discomfort, if not pain. If the hymen is present, the sides of the vaginal opening closely approximate, unless the legs are drawn widely apart. The introduction even of the tip of the little finger shows that the parts are sensitive, and also creates pain. The sensitiveness of the privates of girls is a safe-guard to them, and is lessened mainly by thickening, resulting from inflammation, such as that caused by a vaginal catarrh, or a gonorrhea, or by the repeated introduction of foreign bodies.

We may find on examination a hypersensitiveness of the parts purely the result of a catarrhal inflammation, or a nervous erethism, and, while it is true that, in general, children that are innocent dread an examination, and that those, especially over ten years of age, who have been as-

saulted take an examination as a matter of course, still some of the latter class, like a certain proportion of adult prostitutes, honestly dread an examination.

In determining whether rape has been committed upon girls of ten years and over, it is essential to decide whether they are weak-minded and were overpowered, whether they made sufficient resistance physically to assaults, or by outcries compatible with surrounding circumstances, or whether they had not learned to like the alleged assaults, as might especially be the case with some girls just developing into womanhood—just reaching the age of puberty.

The motives for falsely accusing men of rape are so many and so obvious, being merely the expression of the determination on the part of depraved human nature to "get square" with some one real or supposed injuries, that the fact they exist needs mention only to put us on the alert. Wharton and Stille record a case where a man was accused by a mother of communicating gonorrhea to her child; when on investigation it was ascertained that it was effected by her paramour at her request, so that she could "get square" with the accused man.

It is a curious fact and contrary to reason that an innocent, intelligent, and well brought up girl should submit to assault apparently without a murmur. It is also strange that some intelligent children will tell different stories to different questioners as to the alleged assaults, but school teachers and parents find the same apparent perversity in regard to other matters. This tendency to vary statements must be estimated by the doctor when he is endeavoring to ascertain the whole truth and nothing but the truth.

In fact, the doctor should not be satisfied to pronounce for or against the commission of rape until he has both carefully examined the child physically, and as to the truth and character of her statements. We cannot be governed in our decisions by sympathy for the child, or by antipathy for the alleged assailant. It is facts that we are after, corroborated by other facts. There are doctors who believe they have nothing to do with a case, except to ascertain the physical condition of a child at the time of examination, and there are lawyers who desire them to believe thus. Yet a reliance alone upon a physical examination is unreliable, and will be more manifest when we consider more at length—the usually stated signs of virginity—the methods employed to distinguish the detection of seminal stains on clothing, and the distinction between leucorrhea and gonorrhea.

1st. *As to Signs of Virginity*.—Five are ordinarily given, viz: (a.) An intact hymen, ordinarily considered the most valuable sign of all in a diagnostic point of view. It is conceded that hymens have various shapes, that they may be ruptured by handling, by clots of blood at the menstrual periods, and by the forced introduction of foreign bodies; (b.) An absence of the carunculæ myrtiformes, generally two or three small excrescences upon either or both sides of the vaginal opening, in reality the remains of the hymen, but sometimes warts, vegetation, etc., are mistaken for the carunculæ; (c.) The fourchette, fossa navicularis and posterior commissure entire; (d.) A narrow and rugose state of the vagina; (e.) Plump breasts and elastic nipples, which signs, of course, relate to persons above the age of puberty; (f.) Integrity of the perineum.

Of course the opposite of the above physical conditions in any case would seem to indicate that the individual examined was not a virgin—the greatest value as a sign being placed upon the entire absence of the hymen or the presence of the carunculæ myrtiformes. That the presence or absence of the hymen is not diagnostic, has already been shown in connection with cases. Probably its value as an element in diagnosis has been overrated, because it was supposed that during an attempt at connection the greatest strain would occur at the vaginal opening, and such an apparently fragile structure as the hymen must ordinarily be broken. The laceration of the nymphæ, but especially of the fourchette and perineum, it is generally conceded can only be affected by violent connection. The fact is that among the many cases of rape upon little girls, seldom is it found that violent connection has been attempted, and as we believe the attempt at rape in many instances is only incidental to the main attempt at self-abuse; or the assailant attempting rape solely, is often under the influence of liquor, and fails to break the hymen. There also seems to be a great difference as to the strength of various hymens, and even as to their location. In very young children the hymen is not infrequently musculo-membranous and depressed into the lumen of the vagina. As the child grows older it is, as a rule, more nearly on a level with the opening of the vagina, and is thinner and more membranous. Stories are told of their being so thin as to be readily destroyed during menstruation, or by the wash rag in ordinary ablutions. I have sometimes thought they are sometimes destroyed by catarrhal inflammations of the vagina, or by a gonorrhea. Sometimes they are so strong and flexible that they can be stretched considerably without tearing. Probably because the books give so little

definite information as to the location and character of the hymen, and there is so little that is definite about it known to medical students, it happens that some physicians have never seen one, or have vague notions about it. The books usually speak of the hymen as crescent shaped, attached to the lower edge and to the side of the vaginal opening, and with its free border projecting into the lumen of the vagina. This description is most often true I think as to older children, or to those who are at the age of puberty, or beyond—when the hymen is membranous. I have been surprised to find how often the hymen is circular, especially in very young children, its free border “circumscribing,” as Sappey says, the vaginal orifice.

In the twenty-one cases reported the hymen was plainly perceptible in eleven, but one of these cases includes three children. In three instances the hymen was very pliable, in one its free border was quite thick, in all the septum was strong. In six of the twenty-one cases the presence or absence of the hymen was not clearly ascertained. In four cases it was absent, but one of these cases included five children.

2d. *Examination with Reference to the Presence of Spermatozoa.*—As far as I have been able to ascertain, in most of the instances of rape upon children, semen is either not emitted, or if it is, it is thrown upon the thighs and outside of the vulva, and has been ordinarily washed away before the examination. Probably a microscopical examination should always be made in cases of suspected rape, for spermatozoa might be found when we should least expect to find them. As to the examination of seminal stains upon cloth, I quote from a paper by Dr. F. M. Hamlin, of Auburn, N. Y., read before the American Society of Microscopists, at Chicago, 1883.

“Having occasion, last January, to examine some seminal stains on cloth, I sought to avail myself of the experience of others. I found that all writers on medical jurisprudence and microscopy adopt and recommend the method of Dr. Koblanck. It is briefly as follows: Cut out the portion of cloth suspected. Place it in a watch glass with a few drops of distilled water; let it soak for a few minutes (variously stated from two to ten); stir it about with a glass rod, and then squeeze out the water with the fingers. This squeezing may be done directly upon the slide or into the watch glass, whence a portion may be taken up by a pipette and transferred to a slide.

“Following this plan with a piece of cloth known to be stained with semen, I obtained such poor results that I resolved to try some other

method. Remembering how transparent a fine linen fabric appeared on a certain occasion when I was studying its fiber, I resolved to subject a portion of the cloth itself at once to the microscope. Taking a small piece of the linen and placing it upon a drop of water on the slide, I let it soak for awhile, then put on a cover glass and proceeded to examine it. Almost immediately I discovered a number of spermatozoa clinging to the fibers of the linen or lying in masses in the meshes. Encouraged by this success, I experimented with fabrics other than linen. In light-colored silk the spermatozoa were detected quite as easily as in linen. A firm piece of cotton sheeting proved refractory, till I thought to unravel or fray out the ends, when I readily found the zoosperms adherent to the detached fibers.

"Having experimented with the fabrics commonly used for undergarments, I turned my attention to colored woollen goods. They were not, of course, sufficiently transparent to render the above plan practicable; so with a keen scalpel I shaved off a portion of the stained surface, which fell in a fine dust upon the slide. This was moistened, and after soaking awhile, was examined. The spermatozoa were found even more readily than in the other experiments.

* * * * *

"I, therefore, recommend the following procedures :

"1. If the stain to be examined is upon any thin cotton, linen, silk, or woollen fabric, cut out a piece about one-eighth inch square, lay it upon a slide previously moistened with a drop of water, and let it soak for half an hour or so, renewing the water from time to time as it evaporates. Then with a pair of needles unravel or fray out the threads at the corners, put on the glass cover, press it down firmly, and submit to the microscope.

"2. If the fabric is of such a thickness or nature that it cannot be examined as above, fold it through the center of the stain, and with a sharp knife shave off the projecting edge thus made, catching upon a slide moistened with water the particles removed. After soaking a few minutes—say five to ten—the powdery mass will sink down through the water and rest upon the slide. The cover-glass may now be put on, and the preparation examined.

"The latter plan serves as well for hairs, but great caution must be observed in cutting them lest the portions bearing the suspected deposit fly away and are lost.

"Whichever plan be appropriate, it is best first to moisten the slide with a drop of water. In the former case, by laying the cloth upon the water we get rid most easily of the air-bubbles, and in the latter the water preserves the powdery portions cut off from being lost, and they are not rolled to one side, as when the drop of water is subsequently applied.

"Should it be desired to preserve any of these preparations for production and examination in court, I have found that to hold down the cover-glass with a spring-clip, and run around it a circle of liquid marine glue, serves at least a temporary purpose.

"A piece of stained muslin lay nearly two months without protection upon my working table. I then mounted a portion of it in water, as above described. It now, at the end of five months, shows the spermatozoa as well as ever. For permanent mounting I should suppose the addition of carbolic acid, chloral hydrate, or some such preservative would be of service. I have not found it necessary to use any dye or any solvent except water. A power of three hundred diameters is amply sufficient for these examinations.

"Concerning the durability of spermatozoa, Ritter asserts that he has discovered them after a period of four years. To show how, when dried, they will bear rough handling, I may add that I rolled and twisted between my fingers a stained piece of muslin till it was in the form of a string, unrolled and twisted it over again two or three times, using much force; and was yet able by my method to discover spermatozoa without much difficulty.

"I claim for my plan extreme simplicity, ease of execution, and the greatest degree of certainty, for piece after piece of the stained fabric can be put to the test with the assurance that nothing in the process destroys the spermatozoa, and that they may be found if present."

3d. *The Distinction between Leucorrhœa and Gonorrhœa.*—Vaginal catarrh is so common, either as the result of a scrofulous diathesis, the irritation of worms, or the presence of dirt and filth, especially among the very poor, that we can safely assume that most cases of running at the privates that present themselves to us, are cases of leucorrhœa, unless we find that the alleged assailant has or has had gonorrhœa, that the discharge does not readily succumb to treatment, but grows more profuse, or at least the inflammation associated with it shows a tendency to extend inwards. I do not know that there is any evidence of a diagnostic difference in the character of the discharge, either as seen

by the eye or through a microscope. A severe benign inflammation, especially if the parts are not kept clean, may cause ulceration, and blood will mingle with the mucus and pus, as it sometimes does in gonorrhea.

Says Dr. Alex. Russell Simpson, in Quain's *Dictionary of Medicine*, "Unless a clear history of infection can be obtained, it is almost impossible to establish a distinction between a gonorrheal disease and the simpler catarrhal leucorrhea. In the former there is a notable tendency to spread to contiguous surfaces. In children suffering from the infections discharge, traces of the injuries that are usually inflicted at the period of infection should be sought for."

Berkeley Hill writes: "The distinction between vaginitis from contagion and vaginitis from non-specific irritation is always difficult and sometimes impossible, being mainly determined by collateral evidence. It generally has a contagious origin if there is pus in the urethra."

TREATMENT OF CYSTALGIA IN WOMEN.—Charles Monod gives the following classification of cystalgias in women:

1. Cystalgias due to lesion of the urethra (polypi and fissures).
2. Cystalgias symptomatic of a lesion of the bladder, inflammation, tumor, tubercle.
3. Cystalgias symptomatic of lesions in other organs, as those of the uterus and its annexa, or of the other pelvic viscera.
4. Cystalgias of nervous origin, *e. g.*, symptomatic of locomotor ataxia.
5. Such manifestations as can be traced to no cause, and which may be considered as idiopathic.

The treatment of these various conditions by forced urethral dilatation is advocated:

1. In urethral affections dilatation is beneficial because exerting a beneficial influence upon the spasmodic and painful element of the disease, and also upon the lesion which has produced and maintains the cystalgia.
2. In cystalgia caused by neoplasms, dilatation, while affording temporary relief, can only be recommended as a means of diagnosis, preparatory to the ablation of the tumor.
3. In the treatment of simple cystalgia, injections of boracic acid, nitrate of silver, and sedative preparations should be tried before resorting to surgical procedure.

When urination is persistently painful and frequent, forced dilatation which frequently gives unexpected relief, should be tried before establishing a vesico-vaginal fistula.

Observation shows that this method of treatment causes pain to disappear, and also improves the condition of the vesical mucous membrane, while it also permits the easier application of local remedies. In tubercular cystitis, dilatation may be practised as a final measure for the relief of pain.

4. In conditions designated as irritable bladder, forced dilatation is especially efficacious whether the cystalgia depends upon fissure of the cervix uteri, disease of the uterus, vagina, rectum or anus; indeed, unassociated with any recognizable lesion.—*Annales des Maladies Org. Gen.-Urin.*—*American Lancet.*

COD LIVER OIL TO INFANTS—A very good suggestion has been made by Mr. S. Yeldham, of a plan of administering cod-liver oil to infants. He says: "Let the nurse dip the end of her little finger in the oil and put it into the child's mouth. This may be repeated five or six times in the twenty-four hours. In such small quantities, not only does it never disagree, but the child sucks it off the finger with avidity and evident pleasure. It may be administered in this way to the youngest infant." By this simple and inexpensive expedient, the writer says many infants who were absolutely starving for natural foods became fat and plump, and happily in an almost incredibly short space of time. The oil has the effect of enabling the child to digest other food which it could not retain on its stomach without it.—*London Corres. of Jour. of A. M. A.*

PILOCARPINE IN PUERPERAL CONVULSIONS.—Dr. Geo. T. M'Kecugh thus concludes an article in *The Canadian Practitioner*, January, 1886: "So far as I can learn from the medical literature at my disposal, the use of the pilocarpine in puerperal eclampsia is apparently in an experimental stage of its history. The views of eminent men concerning its use are discordant. Dr. Fordyce Barker gives it as his opinion that, in the treatment of puerperal convulsions, the utility of jaborandi, or its alkaloid pilocarpine, is more than doubtful, and that its depressing influence is so continuous and exhausting as to render it an unsafe and dangerous remedy. Whilst, on the other hand, Dr. T. Gailliard Thomas relates the history of a case before the Obstetrical Society of New York, in which pilocarpine "seemed to exert a remarkably beneficial influence,

and, from the results in this case, hoped much from the drug." Theoretically, it ought to be the remedy *par excellence*. I believe it is now almost universally admitted that convulsions of pregnancy are the result of some urinary poison in the blood, due to the pressure of the gravid uterus upon the ureters, kidneys, and their blood-vessels. Therefore, stimulating the emunctories and the emptying of the uterus are essential steps in treatment which pilocarpine apparently fulfils. It produces almost immediate diaphoresis and ptyalism, thus relieving the toxemia more quickly than by any other known means; and I believe it has been demonstrated beyond a doubt that it has an ecboic action, producing rhythmical contractions of the uterus, and thus promotes labor. In my third case I think it assisted labor materially—probably inaugurated the uterine contractions.

In one of my three cases did the great depression which Dr. Barker speaks of ensue, and in my last two cases the pulse was weak when first administered; the doses of the drug used, however, were smaller than generally recommended; and I cannot think that the excessive and exhaustive perspiration and salivation, which evidently sometimes occur, is produced by the abuse of the drug, and the reducing of the patient to a condition of adynamia may be avoided by the administration of smaller doses than are generally recommended, assisting its action, if necessary, by means of artificial heat. In my last case one-eighth of a grain, with the assistance of an extra blanket and a few bottles containing hot water, kept the patient sweating freely for three hours. In my last two cases a degree of restlessness followed its use, which was, however, speedily controlled by the use of sedatives—morphia in one and chloral in the other. But there is a danger, as illustrated by my first experience, to be feared in certain cases, viz. : pulmonary edema and the flooding of the lungs with excessive secretion. I think this can be learned from the record of these cases: that when the coma is profound, and has almost extinguished the action of the reflex centres, as in my first case, pilocarpine is a dangerous agent, on account of the impossibility for the patient to get rid of an enormous quantity of bronchial secretion and saliva which floods the respiratory passages; but in those cases in which the physician is called, before the patient has many convulsions—when the poison has not suppressed entirely the action of the reflex centres—when the patient is partially conscious, probably restless, and moaning, or when convulsions have not occurred, but seem imminent,—it is my conviction that we have in pilocarpine a most valuable adjunct in the treatment of this dreaded disease.

PUERPERAL FEVER—In the Vienna school puerperal fever is known as septic infection, depending (1) upon the local lesion ; (2) the infection of these local lesions. Then follow : (1) high fever and inflammation of the genitalia : (2) peritonitis, or pyemia. There are three varieties recognized.

First. Puerperal peritonitis, or puerperal endometritis, with a symptomatology of fever, unclean lochia, meteorismus, vomitus, and peritonitis. Postmortem section shows endometritis consecutiva, salpingitis and peritonitis purulenta, with exudations.

Second. Puerperal metro-phlebitis or pyemia without peritonitis, the septic virus passing through the placental sections to the uterine veins. As symptoms we have : High fever, chills, torpor, subinvolution of the uterus. The abdomen is flaccid and painless on percussion. There may be icterus and metastatic phlegmon.

Third. Peritonitis plus pyemia, or lymphangitis uteri, or phlegmona pelvis septica.

The treatment is local when a woman begins to have fever on the second day post partum. The external genitals and vagina are washed with 1-2 per cent. carbolyzed water, or with a 1-5000 sublimate solution. When operations have taken place, and the lochia are pathological, and there is high fever, the uterus is irrigated, a glass tube being used. Iodoform bacilli, containing 5-6 grms. of iodoform, are placed in the uterus. The formula used is : *R.*. Iod. pulv., 18 parts; Amyl. puræ; Glycerinæ; Gum arabic, aa, 2 parts.

Ice applications to the abdomen are used in peritonitis incipiens. Ergot is used internally. The antipyretics used are quinine, 1-2 grms. daily; sod. salicyl., 3-4 grms. daily; antipyrin, 1-2 grms. daily. If these do not avail, the cold bath is resorted to. Alcohol is used freely in pyemia, but never in peritonitis. In incipient peritonitis the following treatment obtains : Ice pills; ice cataplasms on abdomen; opium by the rectum, and quinine by rectum. In puerperal ulcers local applications of iodoform, or of iodol (which is expensive but devoid of odor), are resorted to. Salicylic amylum (1 part of the salicylic acid to 5 parts of amylum), has also its merits. It has been found that the cases of puerperal metro-phlebitis, although attended with metastatic transference of the poison, forming abscesses and involving the lungs themselves, tend, in a large percentage of cases, to recovery; while those cases of puerperal peritonitis almost always end fatally. Women seemingly moribund, in whom the whole system is poisoned, begin to recover as soon as elaborate metastatic action obtains. These patients are given alcohol very freely.—*Jour. Amer. Med. Ass.*

SURGERY.

ON THE TREATMENT OF NEVUS.—At a recent meeting of the Clinical Society of London, Mr. R. W. Parker stated that he divided nevi into three chief classes, the cutaneous, the subcutaneous, and the mixed variety, the last mentioned being by far the most numerous. For cutaneous nevi one of the simplest and most efficacious methods of treatment was the application of fuming nitric acid; for the subcutaneous variety, he advocated electrolysis or excision; for the mixed variety, excision was regarded as the surest and most speedy as well as the most radical method.

Mr. Golding Bird had found good results from the ligature. He took exceptions to the sweeping statement that excision should be applied to all cases. Ligature was much preferable in cases which occurred in out-patient practice. A less scar ensued after ligature than after excision, and this latter method was inapplicable to scaly nevi. In nevi below the lower eyelid, and at the end of the nose, the galvanic cautery alone could be employed, and neither ligature nor excision could be, in this situation, adopted. Properly employed, the cautery left a minimum of scar and the least amount of contraction, cicatrization being slow, and cauterization frequent at first; in all such treatment the cautery should invariably be applied circumferentially. Mr. Golding Bird had lately employed this practice very often.

Dr. Ward Cousins thought the knife was the best treatment in some cases, but in others the worst. Some nevi got well under any treatment whatever. Nevi affecting the lids and nose, etc., ought to be very slowly treated; he himself treated them by frequent and long continued scarification by a knife. He approved of the large use of the actual cautery, and never now employed injection, and never used the ligature under any circumstances whatever.

Mr Parker, for nevi about the nose and eyelid, employed electrolytic needles. He advocated excision as being a radical cure, and because the after treatment was so simple, especially when the edges could be brought well together.—*Amer. Prac., and News.*

THE PARISIAN MODE OF OPERATING FOR CATARACT.—De Wecker first washes out the palpebral aperture by a fine jet of solution of bichloride of mercury, 1 in 2,500, then makes his section with the thinnest possible knife, by means of puncture and counter-puncture. This done,

he does not perform iridectomy, nor does he lacerate the capsule in the usual way, but bites a large piece out of its center with a fine cystotome forceps. After pressing out the lens with the back of a curette, he injects a solution of eserine into the anterior chamber by means of a delicate drum-syringe, and one sees an immediate contraction of the iris to a pin's point, and a circular pupil. The eye is again carefully washed by a stream of bichloride, and then covered with a dressing of eserine, glycerine, and bichloride, which is changed daily. De Wecker assures me he has not had a suppuration this year.—*Cor. Cin. Lancet and Clinic.*

A SIMPLE METHOD OF REMOVING WENS.—Dr. C. Lauenstein, Hamburg. The skin over large wens of the scalp is often so thin, that in the commonly practised method of extripation the sac is often ruptured in spite of all care, and in consequence its separation from the skin is rendered difficult. This accident, unless it is a case of inflamed wen, may be avoided by a simple expedient. After shaving and cleaning the neighborhood of the wen, I make a radial cut, half an inch long, through the skin where it is separated from the capsule of the wen, at the lowest point of the base of the tumor; through this slit I introduce the slender handle of a scalpel or a similar instrument, between the skin and the sac; this is very easily accomplished. I then by sweeping movements of the scalpel handle to the right and left, separate the sac from the skin. The elasticity of the skin allows almost the whole circumference of the wen to be separated in this way in a few seconds. I then cut with one snip of the scissors the skin over the tumor as far back as is necessary, and shell it out.

THE TREATMENT OF VARICOCELE.—Dr. R. F. Weir contributes the following to the New York Medical Record:

1. The plan of Gagneles, sub cutaneous ligation with a single silk thread.
2. Ricord's plan, by the *serre-nœud*, or double-loop silk ligature, one in front, one behind, arranged so as to form a running reef-knot, with outside traction by a horse shoe racket.
3. Wood's plan, similar to Ricord's, only differing in that he used silver wire, and brought the ends out through one opening.
4. The modification of Wood's plan by Weir, in which an elliptical spring straddled the scrotum and pulled upon silver loops arranged like those of Ricord.
5. Barwell's modification, in which he thrusts the ends of the wire

through perforated plates with little uprights, to which he fastened the wires and tightened from day to day.

6. The method of sub-cutaneous ligature with aseptic catgut—"one of the best, safest, and quickest in its results."

7. Excision of the veins. Nicaise and Nebler advise separating the artery from the veins, a procedure unnecessary as well as extremely difficult. Reginald Harrison ties the larger veins separately through an incision and lightly cauterizes the smaller ones with the Paquelin.

8. Ablation of the rapheal portion of the scrotum and ligation with catgut. (For this ablation a special instrument has been devised by Dr. Henry, of New York City, called Henry's clamp.)

Conclusions of Dr. Weir.

1. For small varicoceles, the single (or double) sub-cutaneous ligature (catgut).

2. For medium-sized varicoceles, excision.

5. For large varicoceles and for relapsed cases, and for those not large, but associated with redundant scrotum, ablation of the scrotum with ligation.—*Amer. Prac. and News.*

COLUMBUS MEDICAL JOURNAL.

EDITORIAL.

Heating and Ventilating.

The connection of the heating of a house with its ventilation is, of course, inseparable. Many persons will cheerfully expend ten or fifteen thousand dollars in building a house, putting from two to three thousand on outside ornaments, who would not dream of spending five hundred or one thousand dollars for the necessary Hot Water Apparatus to keep this same house thoroughly and comfortably warmed and well ventilated.

In reading the reports from the various Boards of Health, one can not fail to notice the startling increase in the death rate from Scarlet Fever, Diphtheria, and allied diseases. It might safely be said that this condition of affairs is due to the fact that the tightly closed doors and windows, which cold weather makes necessary, prevents the ventilation of houses, which is essential to the maintenance of health.

To those who intend erecting a dwelling, we would advise that the matter of heating and ventilating be given much consideration; and before deciding how it shall be done, consult the A. A. Griffing Iron Co., Manufacturers of the Tompkins Hot Water Indirect Radiator, 518 Communipaw Ave., Jersey City, N. J.

Fluid Forms of Hydrastis.

The reputation of this drug as a therapeutic agent was first gained through its employment in the form of an *infusion*; and in the fifty years following its introduction into medical practice, a continuous effort has been made by manufacturers to perfect a preparation which would represent all the active principles of the drug, without the high price of the salts, either alone or in combination.

The most prejudiced writers on *Materia Medica*, accord to the late Wm. S. Merrell the largest share of credit in the introduction of Hydrastis preparations, and to the present organization the reputation of being the *largest consumers of the drug in the world*. For more than a half-century, Hydrastis has been made a study in our laboratory, and we do not think we exaggerate its importance when we assert that it stands pre-eminent to-day as the most valuable exponent of our vegetable *Materia Medica*.

The following preparations in *fluid form* are receiving our special attention at this time:

Fluid Hydrastis—MERRELL.

Is what its name implies—the active, medicinal principles of the drug in natural combination and in a fluid form. It has a bright, yellow color, perfectly clear, free from sediment, and with an unmistakable odor of the *fresh drug*.

Fluid Hydrastis is a pure, neutral solution of all the alkaloidal constituents of the drug, rejecting the oil, gums, irritating and offensive resins and inert extractive matters. The success attending its introduction is the best evidence of its therapeutic value.

Unsuccessful imitations and would-be substitutes are met with on every hand. Preparations said to be “just as good” or “about the same thing,” but always “a little cheaper,” attest the wide-spread and growing popularity of Fluid Hydrastis. All such, compared with the latter as to physical appearance or as representatives of the drug, *are condemned*; dispensed in prescriptions, *they are readily detected*; tested therapeutically, they are *promptly rejected* as unworthy of confidence.

Fluid Hydrastis is applicable to the treatment of all irritable, inflammatory and ulcerative conditions of the mucous tract.

This statement of a well-known medical writer and journalist has become axiomatic:

“No remedy for physician's use has been received with such universal approval.”

Solution Bismuth and Hydrastia—MERRELL.

An invaluable and scientific combination, wherein the beneficial action of the white alkaloid is increased by association with Bismuth. This solution contains $2\frac{1}{2}$ grains of the double Citrate Bismuth and Hydrastia; twenty-five per cent. of which is Hydrastia Citrate.

The cordial reception accorded this preparation marks it as the most valuable combination in the market in which the white alkaloid alone represents the valuable properties of the drug. Used in diseases of the nasal passages, of the eye, of the throat, of the stomach and intestines, of the reproductive organs and bladder it is equally beneficial.

Colorless Solution of Hydrastia—MERRELL.

This is a permanent solution of the white alkaloid, without the addition of any other medicinal agent to modify or increase its action. It is offered without special recommendation to meet the views of an unlimited number of physicians, with whom the color of the Fluid Hydrastis is an objection. This solution contains in one fluid pint the same proportionate strength of white alkaloid as exists in an average quality of crude root.

See notes above on Solution Bismuth and Hydrastia.

“Merrell's Hydrastis Preparations” are for sale by Wholesale Druggists throughout the United States. Please Specify “Wm. S. M. Chem. Co.” in ordering or prescribing.

The WM. S. MERRELL CHEMICAL CO..

CINCINNATI.

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EDITORIAL DEPARTMENT.

J. F. BALDWIN, M. D., Columbus, - - - EDITOR.

Communications, reports, etc., are solicited from all quarters.

Authors desiring reprints, will receive fifty, free of charge, *provided* the request for the same accompanies the article.

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We have *no authorized Collectors*, except such as carry properly made out bills, *counter-signed by the Publishers*.

HANN & ADAIR, Publishers, Columbus, O.

RETROSPECT AND COMMENT.

We have now entered on our eleventh year of continuous editorial work. As we look back upon the decade that is past, and upon all the changes that time has brought about, we can see many things that might have been ordered differently, and for the better; and yet, on the whole, the retrospect is not unpleasant. Certainly so far as our editorial work proper is concerned, we can see little that we would have changed. We have always had the courage of our convictions, and have never hesitated to speak out for what we thought was right, and against what we thought was wrong; and our language has usually been unmistakable. Perhaps there has been, occasionally, a little too much of the personal element, but it must be remembered that the provocation has been great. It is all very well for our clerical brethren to preach the turning of the unsmitten cheek to the smiter, but in practice he only succeeds who responds straight from the shoulder.

In the management of the JOURNAL we have tried to make our department of "Selections" the most important and valuable. With the whole field of medical periodical literature to select from, we have endeavored to select only what was valuable. To do this we have been obliged to omit all that was hypothetical and visionary: we have given no space to mere theory—we have sought for plain facts. In the lines of diagnosis and treatment, our pages will safely challenge comparison with those of any of our contemporaries. In our original department, we have inserted such matter, of that which was offered, as we thought was valuable. We have not printed articles simply to please the writers, or to fill space; nor have we encouraged the production of such trashy com-

munications as fill some of our exchanges, and which no intelligent physician can read without feeling humiliated.

That our course of management and supervision has been appreciated is shown by our large subscription list. But we have great confidence in the *vox populi*, and it may be that many of our readers would like to see certain changes made, or innovations adopted. If so, we hope they will not be backward in expressing themselves; we are always glad to receive criticisms, whether favorable or not, and hope none of our friends—and we count all our subscribers as such—will hesitate to express themselves, fully and freely, as to the editorial management or the work of the publishers. Let us hear from you, that we may make the JOURNAL, in the next decade, even more valuable than in the past.

NEW MEDICAL SOCIETY.—A number of the leading physicians of Harrison county met at Cadiz, July 12, and organized the Harrison County Medical and Clinical Society, electing officers for the present year as follows:

President, Dr. D. J. Snyder, Scio; First Vice President, Dr. West, Hopedale; Second Vice President, Dr. S. B. McGavran, Cadiz; Secretary, Dr. J. S. Duff, Cadiz; Treasurer, Dr. Burgess, New Athens.

*The next meeting will be held Sept. 7 at the same place.

ARSENIC IN SKIN DISEASES.—The editor of the *Journal of Cutaneous and Venereal Diseases* is desirous of ascertaining to what extent arsenic is used by American physicians in the treatment of skin diseases, and also the results of their experience as to its therapeutical value.

Information upon the following points is requested of every physician who reads this:

Are you in the habit of employing arsenic, *generally*, in the treatment of skin diseases?

In what diseases of the skin have you found arsenic of superior value to other remedies?

What ill effects, if any, have you observed from its use?

What preparation of the drug do you prefer, and in what doses do you employ it?

The editor's address is No. 66 West 40th street, New York.

NEW YORK MEDICAL MONTHLY.—The first number of this medical periodical, under the editorial care of Dr. J. Leonard Corning, made its appearance May 1. Its corps of promised contributors includes some of the ablest medical men of New York, and with such an excellent editor, there can be no doubt of its literary contents.

IN MEMORIAM.

HENRY G. LANDIS, M. D.

On the twenty-second of May last, at his father's house, in Chestnut Hill, near Philadelphia, Henry Gardiner Landis died. Although it was known that he was failing rapidly, and that his death was only a question of time, yet to those who knew him and loved him, the news came with a great shock. Naturally brilliant, and extremely well educated, Dr. Landis was a man who had already won an enviable position for himself, and had his life been spared for further study and work, would have gained an undying fame. Born in Philadelphia in 1848, had he lived until the fourth of June, he would have completed his thirty-eighth year. To few men it is given to accomplish so much when so young, to be so well known to the world of medicine, and at the same time to be so well read in general literature, English history and Biblical studies. His parents came from old Philadelphia families, and though his mother died when he was a small boy, yet his step-mother, the sister of Gen. Reynolds, the hero of Gettysburg, filled her place, and the affection he felt and manifested for her was extremely touching. Sent to Lawrenceville, N. J., to school, he went from there to Yale College, at the age of 15, and was graduated when but nineteen years old, the youngest man in a class of one hundred and one. Deciding to study medicine, in company with Dr. J. C. Wilson, of Philadelphia, he was entered as student in the office of Dr. W. W. Keen, and attended lectures at the Jefferson Medical College. For two years after his graduation, he was in the Laboratory of Dr. S. Weir Mitchell, at the old "Chant St. School of Anatomy," and while there fostered and cultivated those habits and tastes for the study of nature in every form, which were afterwards so characteristic of the man. An interne at Blockley Hospital for the allotted term, he began to devote his time and attention to that branch of medicine which was his specialty, and in connection with which his name will ever be remembered—gynecology. In 1871, he removed to Ohio, and settled at Niles, in Trumbull county, practicing medicine in partnership with Dr. Leitch. In 1877, at the advice and through the influence of Dr. Loving, he came to Columbus as the Professor of Gynecology and Obstetrics in Starling College. Of his ability and wit as a lecturer there is no necessity to speak, for those who have attended his lectures can recall more vividly than any pen can describe his inimitable manner, the stores of learning which seemed to flow so easily from his well trained mind, his caustic satire, and quick

discernment. But it was not as a lecturer merely that Dr. Landis excelled. He was a ready and admirable writer, and he is known to the medical world by his magazine articles and papers, as well as by his books. His first work was "How to use the Forceps;" then followed his "Quiz compend on Obstetrics," and his last volume written when his health was failing, and finished shortly before his final illness, has just been published. Those who were his friends, knew how patiently he worked, when every breath was drawn with pain, and he was so feeble that he could scarcely sit at his desk. Although he never lived to see the result of his efforts, yet his masterly treatise on the "Management of Labor" will be his most enduring monument. In 1883, he was a delegate to the American Association which met at Cleveland, and one of the readers in the Gynecological Section. In 1884, he delivered the address before the Alumni Association of Jefferson Medical College, the subject of which was, "The Need of General Culture for the Physician." And there was no man who ever gave a better example of that polish, culture and literary accomplishments than Dr. Landis. A Bible scholar of no mean order, his Greek Testament was his constant companion, and there was not a single theological question, not a single theory with which he was not acquainted. In fact, a clergyman would have to "verify his references" very carefully before he discussed theology with him. A great admirer of Plato, he had studied the "Republic" so thoroughly that he could quote from it with perfect freedom. The whole range of English Literature and History was familiar to him, and in the back of his copy of Green's History is pasted a table of the English Sovereigns, which he made in some leisure moments, to show that Queen Victoria is a lineal descendant of Alfred the Great. An entomologist of a very high grade, his collection of Lepidoptera and Coleoptera filled a large case that stood in his office. A painter in oil, a wood carver, and a photographer, some of his work was perfectly exquisite. In fact, he was one of those rare men who do everything well, and to the little circle of intimate friends, the band of chosen spirits of which he was the leading figure, his early death will ever be a cause of sorrow, while to that larger world which knows him in his writings and publications, it will always be a source of regret, that he who had begun so well and given such signs of genius, had not been spared to follow the which path he had marked out for him self.

G. W. L.

OUR ADVERTISERS.

We thank Messrs. Reed and Carnrick for sample bottles of "Liquid Peptonoids with Cocoa," and "Carnrick's Soluble Food." The latter is prepared especially for a children's food. The former is the popular Beef Peptonoids, in liquid form, with cocoa, and is exceedingly palatable and agreeable. These articles have, in other forms, been too long and well known to the profession to need commendation. A bottle of either will be forwarded gratuitously, to any who will pay for the transportation.

I have used *Lactopeptine* in my practice for some time, and find it an excellent remedy in Dyspepsia, and in *Cholera Infantum* I consider it almost indispensable.—L. McFARLANE, M. D., *Professor University of Toronto, and University of Victoria College.*

I have the pleasure to say that I have used Peacock's Bromides with entire success in vertigo and congestive headache in the case of my wife. It is the best brain and nerve sedative I ever used.—A. L. ANDERSON, M. D., *Rhea Springs, Tenn.*

NEW REMEDIES.—The Rio Chemical Co., of St. Louis, still press onward in the distribution of information regarding four valuable preparations, viz.: Celerina, Aletris Cordial, Acid Mannate and Pinus Canadensis. Their testimonials from prominent physicians are convincing enough to encourage the entire profession to give them all a trial.—*Analectic.*

THE BEEMAN CHEMICAL Co., of Cleveland, O., manufacture a most excellent Pepsin that is highly recommended by the leading physicians of that city. As liberal samples will be furnished the profession on application, send your address at once. This is an article of merit that will prove most satisfactory, and a trial only is necessary to fully establish its value.

MALTINE, the well known tonic, has lately been improved by being made more fluid in consistency, and hence easier of administration. It has also been prepared in combination with cascara sagrada, so as to meet the indications where a laxative is required, as well as a tonic.

REVIEWS AND BOOK NOTICES.

The International Encyclopedia of Surgery. A Systematic Treatise on the Theory and Practice of Surgery by Authors of various Nations, edited by John Ashhurst, Jr., M. D., Professor of Clinical Surgery in the University of Pennsylvania. Illustrated with chromo-lithographs and woodcuts. In six volumes. Volume VI. New York, William Wood & Company, 1886.

This is the concluding volume of this Encyclopedia, and we have yet to hear any words, other than of praise and satisfaction, from any of the subscribers. It is certainly the most complete work on practical surgery ever published. It is not, of course, a text-book for students: it is a work for mature practitioners and surgeons, and in the libraries of such it will occupy a chief place.

This volume treats of the diseases and injuries of the esophagus, intestinal obstructions, diseases of the rectum, genito-urinary diseases, Cesarean section and its substitutes, ovariectomy, diseases of bones, and orthopedic surgery. It also contains an Appendix treating of the construction of hospitals, military surgery, and the history of surgery.

The Library of Wit and Humor. Prose and poetry selected from the libraries of all times and nations, edited, with biographical and critical notes, by A. R. Spoffard, Librarian of Congress, and Rufus C. Shapley, author of "Solid for Mulhooly." Illustrated with fifty choice etchings. In five volumes 8vo: cloth, 400 pages each, \$15. Philadelphia: Gibbie & Co., 1885. Cincinnati: M. E. Morehouse, 227 Main Street, Room 96.

This is, of its kind, a most excellent compilation. Not only are all our modern wits here enshrined—such as Billings, Twain, Holmes and others, but also the ancient and classical ones. It is an excellent work to pick up when one needs a laugh, and also to loan to a convalescent patient whose "blues" need dispelling.

Medical and Surgical Directory of the United States, comprising a list of all the physicians in the United States, arranged alphabetically. Complete in one volume. R. L. Polk & Co., Detroit, Mich., publishers. 1886. Price, \$7.00.

The character and scope of this work are well indicated by its title. It contains the names of nearly 80,000 practitioners, arranged alphabetically by State, city, and post office. Each name is accompanied by information regarding place and time of graduation, when obtainable.

A descriptive article precedes the name of State and Territory, giving its location, boundaries, extent, climate, temperature, population, rate of mortality, mineral springs, medical institutions and societies, and the full text of all laws relating to the profession.

In addition, the 80,000 names are arranged alphabetically, accompanied only by figures, whereby the reader can readily find each name in its appropriate place in the directory proper. This list will enable any one to find the present location and address of any physician in the United States whose name he knows, and will, doubtless, bring many old friends into communication.

The book is a valuable one for many purposes, though of course not entirely free from errors.

The Surgical Diseases of Children. By Edmund Owen, M. B., F. R. C. S., Surgeon to the Hospital for Sick Children, Great Ormond Street, London. 12mo., 585 pages, with four chromo-lithographic plates and 85 engravings. Cloth, \$2. Philadelphia, Lea Brothers & Co., 1886.

Mr. Owen has here embodied the results of his experience in the study of infantile disorders. Chapters are devoted to all the common, and a great many of the uncommon, diseases, deformities and malformations which seek for the surgeon's assistance. Physicians doing a general family practice will be glad to have this manual for reference in their children's cases.

We notice a few points.

For a poultice he recommends a piece of lint wrung out of warm water and applied under rubber tissue.

Of Dwyer's method of passing a tube into the larynx in croup, the author says: "After due consideration, one feels justified in discountenancing it."

In a list of food preparations, he speaks very highly of Carnrick's beef peptonoids, which, he says, "contain the nutritive elements of the meat with the solid constituents of milk and gluten."

For large nevi, reliance can be placed only on the thermo-cautery or electrolysis.

For opening in empyema he recommends the fifth intercostal space. Resection of the ribs should never be done as a primary measure.

We feel like saying "amen" to his opinion of iodine as an external application: "Iodine as an external application seems to have acquired a wide-spread reputation; possibly not a little of its virtue rests in the color it gives to the skin."

Diseases of the Stomach and Intestines. A Manual of Clinical Therapeutics for the student and practitioner. By Prof. Dujardin Beaumetz, Paris, France. Translated from the fourth French edition by E. P. Hurd, D. D., with illustrations and one chromo-lithograph. Cloth: 8vo. pp. 390. William Wood & Co., New York, 1886.

The author, well known as a teacher of practical medicine, thus explains the scope of his work:—

“Although this work is entitled ‘Diseases of the Stomach and Intestines,’ it is less a treatise on the pathology of these affections than on the treatment to which, in fact, all other considerations are made subordinate. I have given especial attention to foods and alimentation. In these disorders hygienic therapeutics occupy the first place. The patient will be much more likely to find the means of his cure in the observance of a strict and well-regulated diet than in the administration of pharmaceutical drugs.”

The translator has done his work well, and the publisher has supplied illustrations as needed, and one chromo-lithograph setting forth to the eye the composition of the principal elements. The volume is one of the series of Wood’s Library of Standard Medical Authors.

A treatise on the Diseases of the Nervous System. By William A. Hammond, M. D., Surgeon General U. S. A. (retired list). Professor of diseases of the mind and nervous system in the New York Post-Graduate Medical School and Hospital, etc., etc., etc., with one hundred and twelve illustrations, eighth edition, with corrections and additions. Cloth: 8vo. pp. 945. \$5. D. Appleton & Co., New York, 1886. Columbus: Geo. H. Twiss.

The author very justly calls attention to the fact that the previous editions have received the approval of the profession beyond that ever given to any other work of like scope and objects published in any part of the world. He has subjected this edition to a thorough revision, and has added a new section treating of tetany, Thomsen’s disease, myriachit, and other obscure affections.

The author’s style is clear, forcible, and to the point. Illustrative cases are drawn largely from the extended experience of the author. The difficulties of diagnosis, which are usually regarded as especially great in many diseases of the nervous centres, are greatly reduced by a graphic arrangement of the symptoms.

Facts and Mysteries of Spiritism. Learned by a seven years’ experience and investigation. With a sequel. By Joseph Hartman. Philadelphia: Thomas W. Hartley & Co.

Bosh!

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COMMUNICATIONS.

TREATMENT OF GONORRHEA.

BY DR. MAXIMILIAN VON ZEISSL,

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A Paper Presented to the Ohio State Medical Society, June, 1886.

Translated from the German by G. A. Collamore, M. D., Toledo, Ohio.

I will now collate various more recent accounts of the treatment of gonorrhea since the year 1871, and consider their usefulness. Some authors recommend for the cure of chronic clap the introduction of bougies, covered with ointment or drying gelatine, in the diseased urethra; others advise the employment of easily dissolving suppositories, which contain a greater or less dose of the astringent remedy. I can only declare as to this that I have obtained no better results from this mode of treatment than from carefully managed injections. Cleborne, in 1871, after he had used this method for ten years, was compelled to make similar assertions. He made bougies of a lead rod of suitable size, with the end carefully rounded. After the point of the bougie had been split to the depth of one-fourth of an inch, the ends were beveled. If such a bougie be dipped in vinegar or nitric acid until covered with a coating, a more rapid cure may sometimes be accomplished with it than with a bougie made of lead alone. Cleborne

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~~covered~~ a bougie with carbonate of lead and cacao ~~that in this way the astringent metallic salts, tannin,~~
~~incorporated.~~ Soluble substances may be combined with
~~with which the bougie is anointed.~~ This method,
~~recommends itself for its ease of management and~~
~~the application of the incorporated medicament~~
~~mucous membrane; but an unvarying result is to be~~
~~this mode of treatment as little as from every other.~~
~~in similar manner medicated metal sounds have been~~
~~of Auspitz, Unna, and Leopold Casper.~~ Unna usually
~~covered with an astringent ointment.~~ He medicates
~~introducing them, correspondingly bent, into a glass~~
~~shaped like a half moon, filled with the melted ointment, and~~
~~bringing them up to dry.~~ The ointment recommended by Unna is
~~at ordinary temperature and melts by the heat of the body.~~ In
~~treatment Unna acts upon the endeavor to employ, with~~
~~the effect of the coating of the ointment, the mechanical~~
~~the metallic sound upon the swollen and tumid urethral mucous~~

~~by means of~~ this, by means of previous endoscopic examination, the
~~used on the sound can be dissolved exactly upon the diseased~~
~~Casper noticed some disadvantages in the use of Unna's~~
~~First, increase of discharge after repeated introduction, because~~
~~narrow places were irritated by the hard ointment mass.~~ Second,
~~unsuccessful in introducing the covered sound, one must wait till~~
~~ointment melts, but, as it will be wiped off by the narrow parts~~
~~the urethra, it will have no effect on the the parts behind the~~
~~urethra, where it should properly belong.~~ Third, one should avoid
~~introducing cacao butter into the bladder, unless positively necessary.~~
~~Casper has, indeed, in consequence of this mode of treatment, seen~~
~~a simple gonorrhea anterior transformed into a gonorrhea posterior~~
~~and cystitis colli with violent tenesmus.~~ (Similar symptoms may espec-
ially be observed in energetic treatment of the pars membranacea and
prostatica.) Casper twice saw epididymitis arise during this treatment.
To avoid these evils Casper had constructed a channeled German silver
sound. This is slightly conical and twenty-five centimeters long. It
has six grooves, about one and one-half millimeters deep, becoming
shallower as they go back, and ending at five centimeters from the

point, so that the sound from thence is smooth. The grooves are filled with a mass which is solid at the temperature of the room.

Casper uses for this purpose Unna's ointment :

Butyr. de Cacao.....	300.00
Ceræ flavæ.....	2.00-5.00
Argenti nitrici.....	1.00
Balsam Peruv.....	2.00

or a three per cent. resorcin salve. Casper found that the argentic nitrate ointment became less active through reduction of that salt to metallic silver. This reduction is caused by great heat and the electrolytic action of the metallic sounds. The German silver sound exercises the least reducing action. The ointment, slightly warmed, is slowly poured into the grooves of the sound, and the sound is drawn several times through the openings of a Charriere measuring scale, to wipe off the superfluous mass and to make the sound smooth, the beak of the instrument being polished with the edge of a stick. The sound is thus rendered entirely smooth, and the transition from the sound to the ointment is not perceived. From ten to twenty applications of the sound were usually sufficient.

This treatment by the sound, judiciously employed, does much good in some cases, but also sometimes fails.

The introduction of medicated bougies, as recommended by Schuster, Lorrey, Reynal, and Pasteur, as also by Tomowitz, has accomplished very good results in some cases of acute or chronic gonorrhea.

Clemens gives formulæ for the preparation of various ointments, which he has successfully employed in the urethra for the cure of some form of gonorrhea and disorders of sensibility, by means of bougies partly fenestrated or channeled the whole length. Less effective would be the insufflation of pulverulent substances into the urethra, for the treatment of chronic gonorrhea, as advised by Besanez, Wilders, and Walicki. Both designed suitable instruments for this purpose.

An important addition to the therapy of gonorrhea has been made in irrigation of the urethra, which I accomplish very simply by means of the ordinary penis syringe. So far as I know, this was first recommended by Burchardt in obstinate gonorrheas, and first made known generally by Ultzmann and Guyon. Burchardt introduces a small flexible catheter, not more than four millimeters thick at most, having a button at the point, from twelve to sixteen centimeters into

the urethra. Further entrance is prevented by rolling a strip of adhesive plaster, in a thick, firm ring, around the catheter at the proper place. Over the end of the catheter is fastened a piece of rubber tubing a meter in length, which is connected with a glass funnel. Three hundred grams of a two per cent. solution of tannin, in which a gram of iodoform is suspended, is now allowed to flow gradually from the funnel through the urethra, the patient being in a recumbent or half-sitting position. In doing this, the funnel is sometimes held only a few centimeters above the urethra; sometimes sixty centimeters or more. More frequently, in order to produce a tolerably strong hydrostatic pressure within the urethra, the escape of the fluid in the urethra is entirely prevented by pressing the adhesive plaster ring against the meatus. By the change between high and low hydrostatic pressure, fresh portions of the injected fluid penetrate into all the recesses of the inner surface of the urethra. It is observed that, even under a low hydrostatic pressure, the urethra contains considerably more liquid than is expected from the usual gonorrhea injections. If the pressure is increased to more than 60-100 centimeters while the meatus is kept closed, the vesical sphincter is overcome and the fluid flows slowly into the bladder. Burchardt has never seen any evil results from this flow into the bladder. The above described washing-out of the urethra is accomplished in 15-30 minutes. Sometimes, in the upright position, fainting occurs, which renders it necessary to remove the catheter at once from the urethra. As the immediate result of this manœuvre Burchardt has sometimes noticed a slight painfulness of the penis, lasting from one to three hours. On the subsequent day the discharge from the urethra is less in quantity and thinner. Burchardt, besides the above, injected a zinc or lead solution in the usual manner, three times a day. In some the gonorrhea disappeared entirely in two days. In others the washing-out process had to be repeated oftener, even to five times, at intervals of two to six days, before complete and permanent cure could be obtained. This procedure is especially operative in gleet, when not perpetuated by a stricture. Weiser injects through a catheter solutions of zinc sulph. 2.00-3.00, tannin, 0.50, water, 500.00 at a temperature of twenty-six degrees R. (90.5 degrees F.) The bladder must be evacuated after the removal of the catheter, whereby the urethra must come into immediate contact with the medicament through its whole length. In 1883 Curtis recommended the irrigation of the the urethra with water of 108-109 degrees F., and the subsequent injection of the following liquid :

1883

Acidi tannici	
Iodoformi.....aa	3.00
Glycerini.....	35.00
Aquae font. dest.....	150.00
S. Califere et agita.	

This procedure should be repeated every twelve or fourteen hours. By this means Curtis claims to have cured twelve cases within three days, two by a single injection of the whole urethra. In six cases the disease lasted six to ten days; a case of nine months' standing was cured in seven days. Curtis's irrigation apparatus consists of a tin vessel, heated by a lamp, and hung to the ceiling. From this a rubber tube, provided with a stop-cock, leads to a pliable English catheter, No. 8. Internally, Curtis prescribes bicarbonate of soda.

Diday, since E. Besnier has established blenorrea of the urethra as a parasitic disease, has abandoned the hitherto customary treatment by injections, which, in view of the art and manner of their use and the disease against which they are employed, he declares to be totally inadequate. Injections must be totally anti-parasitic and addressed to the characteristic peculiarities of the parasites. The leading principle must have reference to two circumstances. 1. The nature and limitations of existence of the parasites. 2. The structure and function of the urethra; in other words, the praxicidal agent must be directed at the same time to the microbes and the living tissue. To satisfy the first point, the anti-parasitic fluid, as we have not to deal with isolated individuals, but with colonies, the members of which are constantly increasing, must, *a priori*, continue in action for a long time and uninterruptedly, say five to six hours continuously. The remedy itself must be used at first in weak, later in progressively stronger, solutions; of corrosive sublimate, for instance, a commencing solution of 1 to 10,000 would be sufficient. With respect to the action on the urethra, the injection must fill three indications: 1. To come in contact with the whole diseased portion of the urethra. 2. Not only to touch this, but to distend it to a certain degree, and 3. To continue in contact as long as mentioned above. The necessary instrument for these injections would be the common irrigator, the canula of which carries a long, elastic rubber canula. The patient introduces this six centimeters into the urethra, later, if required, deeper, by the aid of a sound. As the parasites lie in masses deep in the folds of the tissues of the urethra, it is necessary to avoid, aside from the washing, any stretching of the mucous mem-

brane, which occurs from a moderate distention of it. To this end, the patient needs only with the forefinger and thumb to press the glans penis upon the canula, and with the other hand at the same time turn the stop-cock of the irrigator. He continues this injection for some minutes; then he opens the cock again, removes the pressure upon the glans, and allows the solution to go in and out, always alternating the two manipulations.

In the course of treatment increasingly stronger solutions of the paraciticide are used.

The treatment of gonorrhea practiced by Ultzmann has, from his distinguished work in the Vienna Clinic on Pyemia, so become the common property of physicians that I need not consider it exhaustively, but merely briefly mention the brush apparatus for the anterior urethra, Ultzmann's irrigation catheter for the neck of the bladder, and his and Guyon's urethra injector. I will also call to mind the "Treatment of the Neck of the Bladder," mentioned by Ultzmann, by means of small suppositories. At this place also the cold-coil of Winternitz may be mentioned. Here, finally, may also be mentioned that Horand has recommended the introduction of ice into the rectum in dysuria and ischuria from gonorrheal cystitis. Horand was lead to this treatment by Caze-
nave who advised it in hypertrophy of the prostate and strictures of the urethra. Of medicines to be used internally, the kava-kava was first prescribed by Dupony, tincture of sandal wood in the acute stage of clap by Lober and gурjun balsam, both internally and locally to the vagina, by Vidal. Within the past year corrosive sublimate and nitrate of silver have been advised, with special reference to their efficiency. Cheyne recommended the following treatment: After the patient has emptied the bladder, a cacao butter bougie of calibre nine or ten, containing five to ten grains of iodoform and ten drops of oil of eucalyptus globulus, is introduced four to six inches into the urethra. Before the introduction the bougie is dipped in eucalyptus oil or carbolic acid, one to twenty, and after being introduced is fastened into the urethra by a suitable bandage. The patient must now pass no urine for four to five hours. In serious cases the bougie is again introduced at night. In the evening, and in severe cases, on the second day, the patient begins to make injections four or five times a day, of an emulsion made of oil of eucalyptus and gum arabic, of each thirty-five parts, water 700-1200 parts. After three or four days these injections are changed for one of sulphate of

zinc (0.14-35). In one or two days the purulent discharge decreases; in four or five days becomes mucous, and ceases in seven to ten days.

I have tried all these methods here cited, and can say of them that in some cases of chronic gonorrhea they sometimes effect cures, while in other cases they have left me in the lurch. In the greatest number of cases I have found complete satisfactions in the ordinary gonorrhea syringe, and in the majority of cases, where I could not accomplish a cure with this, neither could I with the complicated methods above mentioned, which I can only consider useful as auxiliary influences in a prolonged treatment by injections.

As the best means of hastening the cure, I must mention the successive introduction of steel sounds, first recommended, so far as I know, by Mr. Zeissl, for chronic gonorrhea, next to which come medicated bougies and irrigation of the urethra. A substitute for the medicated bougies may be had by pushing a piece of a gelatine or cacao butter suppository, containing zinc sulphate or other medicament, into the posterior part of the urethra, by means of a flexible bougie or Dittel's medicine carrier, and allowing it to dissolve there. This can be done every second day. Hemorrhage from the urethra frequently follows the introduction of medicated bougies or the insertion of similar suppositories in the membranous portion; usually, however, only an increased secretion of pus and mucus results. In fact, the chronic catarrh is kindled to an acute one, and this is the more readily cured. As soon as the increased secretion has ceased, one may restrict himself to the injection of some astringent fluid.

Irrigation of the urethra is especially to be advised in frequent tenesmus, without hemorrhage; in case of the latter, very strong injections in the urethra must be avoided. After a single syringing of the urethra up to the bladder with luke-warm water, the tenesmus diminishes in the majority of cases, and often disappears entirely. Exceptionally, should this injection by means of the penis syringe not reach the bladder, then a catheter may be introduced to the membranous part, according to Ultzmann's proposal, and the injection made through that. Failures of injection with the ordinary surgeon's syringe—I have hitherto experienced but two—are due to the opposition of not only the compressor urethrae, but the whole urethral musculature. For, in these cases, I must employ unusual force, after inserting the catheter in the membranous portion, to drive the fluid into the bladder. In such cases, the spasm of the urethral muscles must be allayed by the appli-

cation of narcotic urethral suppositories. For, so long as the urethral spasm remains, the clap is not cured, and so long as there is very great spasm of the urethra, the injection of fluid into the bladder always requires great patience. But even in the highest degree of urethral contraction fluids can be carried into the bladder by sufficient perseverance.

Irrigations of the urethra seem to me to operate favorably, less through the character of the injected fluid than by the distension and equable pressure, which they exercise upon the wall of the urethra. As to Curtis's hot water irrigation, I can not say much commendatory. In a single case of acute gonorrhea I saw an essential improvement, that is, a rapid decrease of the abundant secretion, follow, after I had run hot water through for a quarter of an hour. In twenty-nine other cases of partly acute, partly chronic clap, this expedient had no effect at all. I raised the temperature of the water to fifty-eight degrees C., which the patients bore very well.

As to the measures recently recommended in gonorrhea, which aim to destroy the gonococci in the promptest manner, as sublimate and silver nitrate, I can establish no better results than from the astringents hitherto in use. Of sublimate I prescribe one centigram to 250 or 200 grams of water; of silver nitrate one centigram to 300 or 350 grams of water. The latter often causes, in great dilution, considerable pain or feeling of weight.

In spite of all the arguments to the contrary, I must insist that the potassium permanganate, in a solution of three or four centigrams to 200 grams of water, gives me the best service in the treatment of gonorrhea—at the least, not inferior to the sublimate and the nitrate of silver.

I can with safety affirm that in a great number of cases, I have succeeded in curing gonorrhea in eight to twelve days by the injection of permanganate of potassium.

The great expectations in therapeutics caused by the invention of the endoscope, have, unfortunately, only partially and in small degree been fulfilled.

No abortive treatment of gonorrhea has as yet been discovered. Advantage is derived, in many cases of dysuria and acute suppurative prostatitis, from the introduction of pieces of ice into the rectum. Internal treatment with balsamic medicines is a good adjuvant; but the far-famed kava-kava, as H. Zeissl showed long since, is of no service against gonorrhea.

If we look back, we must confess that the direct management of clap has made material progress in the past few years; but, unfortunately, we know no infallible therapeutic procedure for all cases. And as I said before, so must I still say, in the management of gonorrhea the most skillful surgeon is sometimes wrecked.

EXTIRPATION OF THE UTERINE APPENDAGES WITH CASES.

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(Read before the Ohio State Medical Society at Akron, June, 1886.)

Extirpation of the uterine appendages has been done to meet a variety of conditions. The original operation of oophorectomy, as practiced by Battey, was to precipitate the menopause and thus do away with persistent dysmenorrhea. Tait extended the operation by extirpating the Fallopian tubes as well as the ovaries. The conditions calling for this complete ablation of the appendages were chiefly intra-tubal, viz. hydro, pyo, and hemato-salpinx. The ovaries did not figure in the conditions, which, to Mr. Tait's mind, called for the extirpation of the tubes; but as the ovaries would be worthless without their oviducts, they, too, were removed. The propriety of this procedure was confirmed by the fact, soon ascertained, that the removal of the ovaries did not add danger to the original operation. Since that time various other pathological conditions have been found to be best overcome by either Battey's or Tait's operations. Intra-mural myomata, giving rise to exhaustive hemorrhage and occurring in women who are yet a number of years away from the change of life, have had their growth arrested and the attendant hemorrhage subdued by the removal of both the ovaries and tubes; not by cutting off the circulation, which is not done, but by removing the controlling influence which the appendages appear to exercise through nervous channels over the nutrition of the uterus. Cases of epilepsy, and of hystero-epilepsy, in which the ovaries appeared to be the exciting cause, have been cured by the extirpation of those organs, even when the latter presented no gross evidence of disease. Cases in which one or both ovaries have been displaced into the cul-de-sac of Douglass and have become adherent, giving rise to painful ovulation and menstruation, and rendering the conjugal relations unbearable and abhorrent, have been recognized very latterly as proper subjects for oophorectomy. Hernia of the ovary (femoral or inguinal) of long standing and irreducible, should be operated upon by removing the extruded organ. We see, therefore, that instead of the one condition which Battey had in mind when he did his first oophorectomy, nine or ten are now recognized as demanding, in certain cases, extirpation of the appendages.

Among my cases of abdominal surgery occurring last year are the following undertaken for the removal of the uterine appendages. Although limited in number they illustrate the extension of this operation as outlined in the preceding paragraph. The following paper, therefore, represents brief synopses of such cases only, to the exclusion of laparotomies undertaken for the removal of ovarian cystomata, uterine myomata, or for explorative purposes.

Ovaralgia with Hystero-Epilepsy—Oophorectomy—Cure. Mrs. M. L. F., American, aged twenty-nine, was married quite young. She had a child within the first year. She had much pelvic distress during her pregnancy, and had never been well afterwards. She had dysmenorrhea and ovaralgia; the latter was constant but was greatly increased in severity at each menstrual epoch. Her former medical attendant, Dr. Voorhes, of Mason, Ohio, had repeatedly treated her for hystero-epilepsy. She came to me in 1882, stating that the troubles just mentioned had grown worse recently. She had an intense vaginitis and some cellulitis. These were subdued, after which I could easily ascertain that there was intense tenderness about the right ovary. I put her on tonics and every species of local and constitutional treatment that I could devise, for more than three years, but she went from bad to worse. The pelvic pain had become entirely localized on the right side, but had become so intense that life was a misery. The hystero-epilepsy had increased in frequency and severity until she was useless to herself and to her family.

September twenty-first, the operation of salpingo-oophorectomy was done by the assistance of Drs. Millikin and Skinner. It was without special incident. An ovary studded with degenerated Graafian follicles was removed through a two inch incision. There was but little vomiting from the anesthetic and the temperature never reached 100°. She was discharged within a fortnight and has never since had a return of her hystero-epilepsy. Latterly she has complained of tenderness in the remaining ovary which, indeed, should have been removed. It is my intention, in subsequent cases of this class, to remove both organs.

Ovaralgia—Oophorectomy—Recovery. Mrs. F. D., aged twenty-six, American, was referred to me by my friend, Dr. G. C. Skinner, in 1883, because of dysmenorrhea and sterility. She had always had dysmenorrhea since the beginning of menstruation at thirteen years. I found antelexion of the cervix, which was successfully treated by forcible dilatation. This, however, only made it more apparent that an important

part of her distress was above the pelvic diaphragm. She was treated by tonics, chalybeates, hygienic regimen and travel, for more than two years. She finally, however, developed a more persistent ovaralgia than she had ever before known, and became clamorous for anything that would afford her relief. She had become greatly amaciated, and to my mind active interference had become imperative. The operation of oophorectomy was done October nineteenth, Dr. Skinner assisting. The only difficulty encountered was the short ligaments which made the application of the ligature (the Staffordshire knot) a matter of no easy accomplishment. The patient was profoundly sick at the stomach for some time after rallying from the anæsthetic, and suffered considerable pain. Her temperature ran up to 102° on the third day when Dr. Skinner, who saw the case for me, discovered decided engorgement of both lungs, which we attributed to the ether used as an anæsthetic. The engorgement, however, readily yielded, and on the fifth day the temperature had fallen below 100° . On the sixth day, however, it again suddenly ran up to 103° , and became vaccillating. I now discovered a small abscess in the lower angle of the wound which was opened and treated antiseptically. The temperature immediately came within 100° and touched normal on the eighth day. She has since had no ovaralgia and has gained thirty-five pounds in weight.

Double Pyo-Salpinx—Tail's Operation—Death. Mrs. A. G., aged thirty-seven, came to me in 1882 for dysmenorrhœa and sterility. She had never experienced a painless menstruation, and had never been pregnant, although it was a fashion of hers to often imagine herself in that interesting condition. She was very anemic and emaciated. She had a small cervix, tilted forward, and, like Mr. Allbutt's nose, it "ran a little." The os was contracted. There was pronounced hardness and tenderness in the region of each ovary and Fallopian tube. The patient informed me that occasionally she had a discharge, purulent in character, which I afterwards ascertained found its way into the vagina through the uterus. The discharge would recur at long intervals and was generally followed by a diminution of the ovarian and tubal pain. I treated the cervix by forcible dilatation and thus removed what obstructive element there was in the dysmenorrhœa. I then resorted to local applications of iodine and cotton tamponade, which afforded but trifling relief. Tonics and constructives were given faithfully for long periods with but negative results. I felt sure I had a deposit of pus within the Fallopian tubes which was occasionally relieving itself by spontaneous discharge through

the uterus. Once, when there had been no discharge for a long time, and when, as a consequence, the pain had grown more intense and the enlargement more pronounced, I determined, as a conservative measure, to aspirate the tubes, through the vault of the vagina. This was successfully done on one side, from three to four ounces of pus being secured; it was, however, a failure on the other side. The tube that was tapped was washed out with a two per cent. solution of carbolic acid. I was hopeful that this would stop the trouble on that side, but it speedily returned. Tentative and palliative measures were resorted to for another year.

November ninth, with the assistance of Drs. Millikin, Skinner and Mr. Felton, a medical student, all the uterine appendages were removed. It was with difficulty they could be found; they were below the pectineal line, well down in the true pelvis and most intimately and firmly adherent to the posterior pelvic wall. Although they were enucleated with difficulty, I was successful in removing them without spilling their contents. A drainage tube was inserted. Great care was taken in washing out the pelvis. The temperature remained at 99° during the first three days; on the fourth it went to 100° , and on the fifth to 101° . The pulse range correlated with that of the temperature. With the rise of temperature, however, there developed marked tympanites. Warmth to the extremities, cold to the belly, and large doses of quinine, marked the decline in the temperature range which set in on the fifth day and continued till the seventh after the operation, when it touched normal. About this time, however, persistent vomiting set in and tumefaction in the region of the ileo-cecal valve was developed. Dr. Skinner, who remained with me in the case, confirmed the opinion that we had obstruction. Remedies by the stomach were but poorly retained if at all. Forcible distension of the intestines with both water and air was practiced faithfully without result. The abdomen was then reopened and some hardened feces which had accumulated at the ileo-cecal valve were forced into the colon; it did not appear, however, that this accumulation was sufficient to account for the obstruction. Numerous lymph-bands were found binding the small intestines indiscriminately; these were broken up. The patient, however, continued to vomit, and died from exhaustion on the eighth day.

No autopsy was permitted. The appendages removed were characteristic of pyo-salpinx. The tubes were distended like sausage, and were

adherent each to its respective ovary, the fimbriæ being obliterated in the adhesions.

Pyo-Salpinx—Operation—Death. Mrs. L. B., widow, aged twenty-seven, applied to me in November. She had had a child at full term ten years previously, followed by pelvic cellulitis and abscess. The abscess discharged itself through the vagina. Since that time she had had distressing dysmenorrhea preceded a few days by a muco-purulent discharge. The dysmenorrhea was of the ovarian variety with the distress located chiefly on the right side. She had had several miscarriages since her first confinement. She came to me for relief from distressing ovarian pain. I found tumefaction above the right fornix of the vagina. Rectal exploration revealed enlargement and excessive tenderness of both the ovary and Fallopian tube of the right side. In spite of some local treatment the pelvic induration and pain increased. The pain was described as pulsating and burning. Suppurative salpingitis with adjacent cellulitis, also possibly suppurative, was diagnosed, and an operation decided upon.

The operation was done November nineteenth, with the assistance of Dr. Cook, now Superintendent of the Oxford Retreat, and Drs. Strecker and Beauchamp. Some difficulty was found in enucleating the ovary and tube, which were intimately adherent to the pelvic wall. The tube was distended with pus but was removed without rupturing it. A small purulent sac of a capacity of three drachms lying between the adherent ovary and the pelvic wall was, however, unavoidably ruptured and its contents discharged upon the denuded surface of the pelvis. The "toilet of the peritoneum" was made with extreme care, a two per cent. carbolic acid solution being used, and a drainage tube was inserted. Vomiting, which began with the first whiff of the anesthetic (A. C. E.), continued for over thirty hours, in spite of cracked ice, lime water and milk, and some carminatives. The temperature, *which was 99.7° before the operation*, gradually arose to 103.4° on the fourth day. The drainage tube was freely used for irrigation but always yielded negative results. The patient died on the fourth day.

Post mortem examination twenty hours after death showed that the primary incision had healed by first intention, and that the surface from which the ovary and tube had been torn was free from pus. There were, however, several small deposits of pus found in the cellular tissue just beneath the area from which the adherent ovary had been removed.

The specimen consisted of the ovary, Fallopian tube and a small purulent cyst adherent to the under surface of the ovary. The ovary pre-

sented a roughened, ragged under surface where it had been adherent to the pelvic wall; it was also adherent to the Fallopian tube. The fimbriae were obliterated in the inflammatory adhesion by which the tube and ovary were made continuous. The tube was distended with pus in which no pavement epithelium was discovered.

Hernia of the Ovary—Extirpation—Recovery. Mrs. Mary P., aged thirty-six, American, widow, came to the Clinic in December, '85, and was attended by Dr. G. O. Cummins. She said she had a lump in her groin that had been there for a long time, that it was extremely painful, that a number of doctors whom she had consulted had told her that she was ruptured, but that she didn't believe them. Dr. Cummins examined the case carefully and reported to me that it was one of hernia of the ovary. On examination I found an enlargement just below the external ring. The peculiarity of the enlargement was that it was exceedingly sensitive, even more sensitive than the ordinary hernias, but was not attended with those reflex phenomena indicative of intestinal obstruction, etc. The patient said she had had the enlargement ever since she was a little girl; that it was always very painful, but that it was particularly sensitive just before she came unwell. She said that it never either increased or diminished in size, but that it sometimes became harder than at others. Several physicians who had pronounced it hernia (of the intestines) and who had endeavored to reduce it had failed in their attempts; one, who went so far as to apply a truss, had nearly killed her during the few days she endeavored to follow his directions. She said that she had never been given an anesthetic when effort had been made to reduce the hernia. She was accordingly placed under the A. C. E. mixture and an effort was made, in the presence of the class, to reduce the hernia, but it was of no avail. Rectal exploration made at this time unequivocally confirmed the diagnosis already made. I told the patient that nothing remained for her in the way of cure, or even relief, but the removal of the extruded ovary.

December 20th, '85, with the assistance of Dr. Cummins, an incision was made over the hernial protrusion. The same precautions were taken in making the incision that are ordinarily observed in operating for strangulated inguinal hernia. The ovary was readily exposed. A silver wire was now passed through the anterior and posterior walls of the inguinal ring and, of course, was made to embrace the ovarian pedicle; this wire was twisted and cut short, after the procedure of my friend Dr. Weist, of Richmond, Ind. The ovary was now removed; the wound

was closed by four sutures and dressed antiseptically. The patient made an uninterrupted recovery, the incision healing by first intention. The result was most gratifying to both patient and doctor.

Pyo-Salpinx—Tail's Operation—Recovery. Miss D., aged thirty, unmarried, came to the clinic in November, '85. She had had no trouble with her menstruation prior to 1883, when she had had a gonorrhea. Ever since that she had had painful menstruation and, what was worse, during the last eight months the pain in the iliac region had been constant but worse at the menstrual epochs. She occasionally had a purulent discharge which afforded her some relief. Physical exploration revealed ovaries that were tender and Fallopian tubes that were both tender and very sensitive. Having learned from experience the futility of palliative measures in cases of pyo-salpingitis, I not only told the patient that such was the trouble, but that nothing short of extirpation of the uterine appendages offered her anything in the way of cure.

With Dr. Cummins as assistant, and some members of the class as spectators, I extirpated both ovaries and Fallopian tubes in January, '86. The operation was comparatively uncomplicated for, owing to the relatively recent origin of the case, the adhesions, which were quite extensive, were not so firm as in cases of longer standing. The tubes were widely distended with pus and were consequently ligated twice and cut between. The possible escape of pus, doubtless abounding in gonococci, was thereby prevented. No drainage tube was used.

The temperature in this case never exceeded 99.5°. There was not an untoward symptom, and the case was dismissed on the thirteenth day.

The specimens consisted of both tubes and ovaries. The tubes were intimately adherent at their distal extremities with their respective ovaries. The amount of pus was approximately one and a half ounces and abounded in epithelium.

Pyo-Salpinx—Tail's Operation—Recovery. Mrs. T. V., aged thirty-four, American, was referred to me by my late friend Dr. E. S. Wood, of Bridgeport, Texas. She gave quite unsuspectingly a history of gonorrhea contracted in 1881. Six months or less after the subsidence of the primary troubles she began to have dysmenorrhea. This increased in severity until it told seriously on her general health. She had tender ovaries and enlarged tubes. The case was undoubtedly one of pyo-salpinx, or more properly, gonorrheal salpingitis. Constitutional and tentative measures had been resorted to for two years, but the conditions remained practically the same as when treatment was begun.

February seventeenth, all the appendages were removed, Dr. Adams assisting. Those on the right side were closely adherent to the posterior wall of the pelvis; those on the left were free. There was but little hemorrhage and a drainage tube was not called for. The incision healed by first intention. The temperature was at no time above 99°. The patient's convalescence was uninterrupted. Dismissed on sixteenth day. Prior to the operation she had become reduced from one hundred and thirty-two pounds to ninety-seven pounds; she has since gained within four pounds of her normal weight and does not complain of an unpleasant symptom.

The tubes contained less pus than is usually found in such cases; in all other particulars they were typical of pyo-salpinx.

Irreducible Displacement of Ovary—Oophorectomy—Recovery. Laura B., aged twenty six, American, married, came to my clinic in September last, complaining of dysmenorrhea, dyspareunia and sterility. She had a copious non-purulent leucorrhea, vaginitis and diffuse pelvic pain which distressed her whenever she made a misstep. She used the hot vaginal douche for a few days and presented herself again when physical exploration was completed. Aside from an endo-trachelitis and a slight ante-flexion, there was nothing abnormal about the uterus. The right ovary was normal and in position; the left was, however, found in the *cul de sac* of Douglass. When I touched it she flinched, and said, "there, that's what gives me all my trouble." She was given an anesthetic and an attempt was made to reduce the displaced organ. The ovary was easily pushed above the utero-ovarian ligaments, but in withdrawing my finger the ovary again came down into the *cul de sac*. Repeated efforts of this kind convinced me that the ovary was held in its position by inflammatory adhesions. I so informed the patient and told her that nothing but a laparotomy offered her any prospect of recovery. She was eager for the operation.

September twenty sixth, with the assistance of Drs. Taylor and Cummins, and Mr. Taylor, of the class, I did the operation. The vagina was packed with cotton to lift the uterus and appendages well up into the pelvis. In consequence of the extreme thickness of the abdominal wall a four inch incision was required. The ovary was found as diagnosed. The attachments by which it was held were the firmest I have ever attacked. There was brisk hemorrhage, which was controlled with some difficulty. The pelvis was, however, thoroughly cleansed so that no drainage tube was inserted. The patient began menstruating the third

day after the operation, on which day the temperature reached 101° . At all other times during her convalescence it was below 100° . The wound healed kindly for several days, when deep, sharply defined ulceration, clearly specific, developed along the line of the incision, and at one or two of the stiches. The patches of ulceration were thoroughly washed with a 2-1000 solution of bichloride of mercury, were dusted with iodoform and sealed with macintosh. Mercury was given internally. From this time on the patient made an uninterrupted recovery.

I beg, in closing, to invite attention to the following conclusions, *viz*:

1. Radical operation was not resorted to, in the cases reported, until conservative measures were first demonstrated to be of no avail.

2. In purulent disease of the Fallopian tubes both local and general medication have no curative value. Tapping, practised in one case, is a dangerous expedient. I am satisfied it complicated the operation under taken a year later.

3. The breaking up of adhesions, however old and firm, in non-purulent diseases of the appendages, is comparatively free from danger. In this fact, as much as in the cure, lies the vindication of oophorectomy in cases of irreducible displacement of the ovary.

4. In inflammatory disease of the Fallopian tubes, resulting in deposits within them, the radical operation should be undertaken at once. Delay, by fostering adhesions, is even more dangerous in these cases than in those of ovarian cystomata. The two fatal cases that mar this report should have been operated on years before. I attribute the disastrous results chiefly to circumstances growing out of delay.

Mr. Lawson Tait says that operations performed for diseases which preclude anything like permanently successful results do not redound to the credit of surgery, or the advantage of patients.

Dr. Ripley, of New York, from experience gained in the treatment of a number of cases, has reached the conclusion that the hypodermic injection of morphia, as first advised by the late Prof. Alonzo Clarke, is in the treatment of aconite poisoning of more value than any or all other means of which we have knowledge.

TAIT'S LAW.—In every case of disease of the abdomen or pelvis in which the health is destroyed or life threatened, and in which the condition is not evidently due to malignant disease, an exploration of the cavity should be made.

Dr. MacLaren, *Edinbuagh Medical Journal*, says that in his student days the theater of the old infirmary was crowded with students and practitioners—he had seen them hanging on the bars which supported the gallery—to witness operations which were now done in the provincial hospitals without any but chance spectators. Operations which used to be done only by the great masters are now done by all surgeons everywhere.

CONTAGIOUSNESS OF VARIOLA AT THE BEGINNING OF THE ERUPTION.—Lancereaux reports three cases occurring in his hospital service, in which smallpox was transmitted at the beginning of the eruption. From these facts he draws the conclusion that variola may transmit itself on the first or at least the second day of the eruption, since the smallpox patient admitted by mistake in the hospital was transferred two days after the appearance of the eruption. This is, however, not the opinion commonly admitted. An English physician of great celebrity, Herberden, following the citation of Dezateux and Valentine, asserted that he was in possession of facts demonstrating that smallpox could not be communicated until after the second or third day of the eruption, and the persons who never had it might, up to this period, sleep with those who had it without risk of taking it.—*Bul. de l'Academie de Medesine*.

A VERY BROAD HINT.—A physician in this city is said to have the following inscription on his bill-heads: "A patient's gratitude to his doctor is a part of his disease, and is most declared when the fever is highest, cools off during convalescence, and entirely disappears with the complete return of health. All bills due upon presentation. Office prescriptions and attendance strictly cash."—*N. Y. Medical Record*.

A CURE FOR FRECKLES.—Dr. Halkin's procedure is as follows: The skin being washed and dried is put on the stretch with two fingers of the left hand, and a drop of carbolic acid is applied exactly over the patch. When it dries the operation is completed. The skin becomes white, and the slight sensation of burning disappears in a few minutes. The thin crust which forms after the cauterization should not be disturbed; it detaches itself spontaneously in eight or ten days, leaving a rosy coloration, which is soon replaced by the normal color of the skin.—*American Practitioner and News*.

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SURGERY.

CONTRIBUTIONS TO PRACTICAL SURGERY. Prof. John Chiene. (Concluded from June issue.) 32. *Amputation of the Hand.* In partial amputation of the fingers and thumb, utilize any available skin for the flaps. Let your main object be to leave as long a stump as possible; do not sacrifice length in order to follow any special method of amputation. Let the cicatrix be, if possible, posterior, using the tissue on the anterior aspect of the digit for the principal covering to the divided bone. When the injury or disease is such as to necessitate amputation at a higher level than attachments of the flexor and extensor tendons to the second phalanx, is it right to go at once to the knuckle and perform complete amputation of the finger? If the tendons can be saved and attached to the bone, then the first phalanx should be left; if this can not be done, then amputate at metacarpo-phalangeal joint.

In amputating a digit, or a digit along with a portion of its metacarpal, avoid, if possible, any interference with the palm of the hand; avoid a cicatrix in the palm; a cicatrix in this position is apt to be tender, and this interferes with the grasping power of the hand.

In amputating a finger do not interfere with the breadth of the hand. In a case requiring removal of one or more metacarpals leave, if possible, healthy periosteum; new bone is formed and a more useful hand is the result. Let this rule regarding the periosteum hold good, very specially, in connection with the metacarpal bone of the thumb. Any osseous projection at the radial edge of the hand is a point of attachment for the muscles of the ball of the thumb, and is of the greatest use as an opposing point to the fingers.

In patients in whom manual labor is their source of income, do not, in amputating the fore and little fingers, interfere with the heads of the corresponding metacarpals, if a sufficient covering can be obtained. In other cases, for the sake of appearance, the head of the metacarpal may be removed obliquely.

Take, if possible, your main flap in amputating any of the fingers from the flexor aspect of the finger. Do not approach the palm in your incisions. In the middle and ring fingers the best result—looking to use and not to appearance—is obtained in the following way: Enter the knife at the knuckle, carry it outwards and forwards towards the web until a point midway between the anterior and posterior aspects of the

web is reached. Do the same on the other side of the finger; these two incisions form a right angle with each other. A flap is then made from the anterior aspect of the first phalanx. The finger is removed, and the flap turned back into position, the apex of the flap fitting into the angle where the incisions begin over the knuckle. By this method the incisions do not approach the palm, the breadth of the hand is not interfered with, and the resulting cicatrix is posterior.

In crushes of the hand save as much as possible; save a finger or a portion of a finger; save any part of the thumb; save any portions of the metacarpals. The most useless natural hand is more useful than any artificial substitute.

33. In *contractions of the palmar fascia* Busch's operation in severe cases affords the best result. In simple cases the subcutaneous division of the tense fibres is generally sufficient. It is to be remembered that there are two directions in which the contracted fascial fibres must be divided, parallel to the skin surface and at right angles to the skin surface; by the first, the fibres at right angles to the skin surface, which dip down between the flexor tendons, are divided; by the second, the longitudinal fibres of the contracted palmar fascia are divided.

Busch's operation consists in dissecting the contracted fascia from the flexor sheaths by a V-shaped flap, the apex of the flap looking to the wrist; the fingers are then extended, and the flap attached with horse hair stitches to the edge of the incision, while the opposing edges of the proximal portion of the raw surface are accurately stitched together. The result is a Y-shaped cicatrix, and an extended finger or fingers with no tendency to subsequent contraction.

34. In *wounds of the palm* the persistent hemorrhage is often due to the palmar vessels being simply punctured, and not cut fairly across. Divide the artery wounded by deepening the accidental wound. Retraction of the wounded vessel takes place, and simple pressure is sufficient to arrest the hemorrhage. Check the force of the blood flow by fully flexing the forearm on the upper arm with a pad at the bend of the elbow. By these means the hemorrhage is arrested; if it still persists, plug the wound in the palm; if this fails, tie the brachial artery.

35. *Whitlow*. In deep-seated digital inflammations over the first and second phalanges, the cause is either an inflammation of the flexor sheath, or it may have a periosteal origin. In inflammations over the anterior aspect of the terminal phalanx, the cause is periosteal, and the worst that can happen is necrosis of the terminal phalanx.

In all cases make your incision early, central, and in the long axis of the finger. Relieve tension, and prevent spread of the inflammation from the flexor sheath on the finger to the common flexor sheath on the anterior aspect of the wrist. In periosteal cases early incisions prevent necrosis of the affected phalanx.

In patients who are liable to whitlows, as in people who suffer from boils and carbuncles, administer corrosive sublimate internally, it is a most powerful antifermentative.

In *inflammation of the common flexor sheath* relieve the tension by making an incision into the sheath in the forearm above the annular ligament. Take care and not injure in your incision the median nerve; adopt Hilton's method to avoid this risk. After opening the flexor sheath in the forearm, pass a curved probe-pointed bistoury from the wound under the annular ligament, divide it with the knife, and in this way the palmar tension is effectually relieved.

36. In *amputation* for injury or disease in the upper extremity, do not follow, at the cost of length, any special method of amputation; get your flaps as best you can so as to obtain as long a stump as possible. The longer the stump the easier it is to fit on an artificial substitute. In severe injuries of the upper extremity in which an endeavor is made to save the limb, more especially in cases in which the bones are injured, in which the line of fracture is oblique, or in which, from comminution of the bones, it is difficult to keep the fragments in accurate position, remember that the use of the extension apparatus is as valuable in the upper as it is universally acknowledged to be in the lower extremity. Thick sheet lead makes a most efficient splint, it can be easily moulded to the injured limb over the dressing; by its weight it steadies the limb and keeps it at rest.

In all *fractures* near the joints the soft tissues are to a certain extent saved from injury when the bone gives way, but still in all cases there must be some injury to the tendons, muscles, joints, and ligaments. These structures require, for the proper performance of their functions, mobility; prolonged rest, to prevent any risk of non-union of the fractured bone, may be followed by stiffness of the neighboring joint, by adhesions of the ligaments, and organized effusion into the sheaths of the tendons. The result is a united fracture with a stiffened joint.

Non-union of bone does not occur in consequence of occasional gentle passive movement along with massage, if in the intervals the parts are kept at perfect rest. Non-union is much more likely to occur if slight

constant movement is allowed between the broken ends. For example, in fracture of the shaft of the humerus, and in fracture of the shafts of the radius and ulna, it is important to keep the elbow-joint at rest by means of a rectangular splint. If the elbow joint is not kept quiet, there is more or less *constant* movement at the seat of fracture. This movement is very different from gentle passive movement every second day, with perfect rest in the intervals, as in fractures in the region of the wrist, elbow, and shoulder.

In Colles' fracture allow the patient to move his fingers and thumb after the first week, and after ten days take off the splints every second day and move the fingers, thumb, and wrist-joint gently. Take off all splints at the end of four weeks. Too prolonged rest in this injury often ends, more especially in old people, in irremediable stiffening of the fingers, thumb, and wrist-joint.

In fractures into the elbow-joint early gentle passive movement at the end of a fortnight every second day prevents stiffness of the elbow joint.

In fractures of the upper extremity of the humerus begin passive movement after a fortnight.

In *dislocation* of the thumb backwards at the metacarpo-phalangeal joint, dorsi-flexion of the thumb, with pressure on the head of the dislocated phalanx is the simplest way to treat the case. In dislocation of the fingers the extension is best made by means of a toy made of plaited strong grass so arranged that it can be easily slipped over the finger, but when it is pulled upon it grasps the finger tightly.

Fractures of the third and fourth metacarpals are diagnosed with difficulty. They are best treated by an anterior splint. Oblique fractures of the phalanges are most troublesome. It may be necessary, in such cases, to apply extension. An anterior splint, carefully padded so that there may be no pressure on the ball of the thumb, stretching from the bend of the elbow well beyond the tip of the fingers, is fixed to the forearm by sticking-plaster. An elastic band is attached to the injured finger by sticking-plaster, and extension is kept up by fixing it to the extremity of the anterior splint.

In fractures of the phalanges utilize the neighboring fingers as lateral splints, padding carefully between the fingers so as to prevent discomfort, excoriation, and itching. Skin should never be allowed to remain for any length of time in contact with skin. In fixing the arm to the trunk in fracture of the clavicle and in fracture of the upper extremity of the

humerus, if a layer of lint is not placed between the arm and the chest much discomfort will follow.

In these fractures it will generally be found that the broken ends of the fractured bone are best brought into apposition by bringing the arm well across the chest, so that the hand lies on the opposite shoulder.

In fixing the arm the use of a long strip of sticking-plaster fixing the limb to the trunk is a simple way of treating these injuries. In green-stick fracture of the clavicle, a common accident often overlooked at the time of the injury, the strip of sticking-plaster is the best method of treatment.

In fracture of the clavicle at the coraco-clavicular ligament there is no displacement. In fracture of the clavicle external to the coraco-clavicular ligament there is no downward displacement, and the forward displacement is not observed at the time of the fracture, but becomes very evident at a subsequent date. Treat all fractures by simple means; let wood, pasteboard, and lead, (in cases in which the patient is confined to bed) be your mainstays; avoid all special forms of apparatus.

In *sprains*, carefully applied elastic pressure, with wadding, combined with massage and passive movement, gives the best results.

In diagnosing an injury look before you touch the limb. Remember the normal relations of the styloid processes in diagnosing injuries in the region of the wrist; the relation of the head of the radius to the external condyle, the relation of the olecranon to the internal condyle of the humerus of the elbow-joint; and let the coracoid process and its relation to the head of the humerus be the principal guiding landmark in injuries of the region of the shoulder.

Always expose the uninjured corresponding region, examine it in the first instance, and let it be your standard (having satisfied yourself that it is normal) in diagnosing the injury on the other side.

38. In *amputation of the toes*, a partial amputation may be performed in the great toe; in the other toes partial amputations are inadmissible; avoid any incision in the sole of the foot. Remember that the foot is a tripod, and that its stability rests on the integrity of three points of support—the ball of the great toe, the ball of the little toe, and the os calcis; interference with any of these lessens the value of the foot as a basis of support. Any narrowing of the foot approximating the two anterior points of support also renders the foot less stable.

Utilize the plantar surface for the principal flap in amputations through the tarsus and at the ankle joint. In amputation at the tarso-

metatarsal joints and in amputation through the centre of the tarsus, after marking out the flaps by incisions down to the bones, it is best to disarticulate and then dissect the bones off the long plantar flap from behind forwards.

In all amputations in the lower extremity sacrifice length in order to obtain a stump that will bear pressure. A painful stump is worse than useless ; with it the patient has no comfort, and can not wear an artificial support.

In amputation above the ankle the long anterior flap gives the best result. In amputations below the knee the modified circular is, as a rule, preferable to the long posterior flap. If the latter method is adopted a posterior leaden splint, curved so as to support the long posterior flap, is the best means of preventing retraction. In all amputations the posterior leaden splint is the best steadier of the stump. Lead as a splint, from its weight and plasticity, makes an excellent splint in many injuries, and after operations both in the upper and lower extremities.

In sawing the bones in amputations in the leg always enter the saw on both bones at once, so that the fibula may be divided before the tibia. In amputation below the knee it is often difficult to secure the arteries. When such difficulty arises take a curved needle, threaded with catgut, and pass it into the tissues behind the bleeding point so as to include the tissues around the vessel in the ligature.

In amputation for injury through the shaft of a long bone the periosteum may be divided at a lower level than the bone ; if this is done it is best to save the periosteum on the anterior surface of the bone, and allow a flap of periosteum to hang over the divided medullary cavity. Do not stitch it for fear of deep-seated tension.

In amputation at the hip-joint amputate by the circular method below the trochanters, tie the vessels, turn the patient round so that he lies on the uninjured side, make a vertical incision over the trochanter, keeping well back where the vessels are not important and the trochanter is most superficial, and disarticulate the head of the bone.

In all amputations for injury in which the patient has lost much blood, save any blood escaping at the time of the amputation, and mixing it with a five per cent. solution of phosphate of soda, as described by Mr. John Duncan, inject it into the main vein before stitching together the flaps.

39. *Ulcers* are due to a local or constitutional cause ; in most cases the local cause is the direct excitant, the constitutional cause rendering

the patient more liable to evil consequences from the local irritation. Unless in the case of a burn or other distinct traumatic cause, always be suspicious of a constitutional cause if the ulcer is situated on any part of the body except the lower half of the leg, and even then be suspicious if the ulcer is on the posterior aspect of the limb. Ulcers are prevented from healing either by a congested or an indurated state of the limb. Simple rest in the recumbent posture, elevation of the limb, and careful elastic pressure are the indications for treatment under which painful, fetid, and spreading ulcers will, with few exceptions, become painless, sweet, and clean. Improve the vitality of the soil, and the putrefactive organisms will die out, not finding a suitable nidus for their further growth and development. The use of antiseptics, such as iodoform and chloride of zinc (forty grains to the ounce), is of secondary importance to an improvement in the vitality of a limb. They are, however, very valuable as adjuncts to the elevation treatment. After the ulcer has assumed a healthy appearance, if the patient must go about, apply elastic pressure *before* the patient arises from bed. This is a most important point, which possibly Dr. Martin was the first to insist upon.

When a patient is brought under your notice with pain in the knee, for which you can not find any evident local reason, always carefully examine the hip; and in a patient who limps as if from hip-joint disease, if you do not find in the hip evident objective symptoms of joint disease, always carefully examine the back. He may be suffering from vertebral disease, with effusion into the psoas muscle under the psoas fascia.

41. In fractures of the leg use the box splint—two pieces of wood rolled in a sheet. See that the foot is kept at right angles to the leg, and thus retraction of the heel is prevented. Take care that there is no eversion of the foot. In oblique fractures use extension.

In fractures of the patella fix to the anterior aspect of thigh a large piece of sticking-plaster, and make through it extension on the quadriceps extensor cruris—elevating the limb on an inclined plane with a foot piece.

In fractures of the thigh use extension with the weight and pulley, take care that the weight is not too heavy, and measure the limb every third day, so that the weight may be reduced. The too prolonged use of the weight may result in delayed union or non-union. In children, in restless adults, and in cases of delayed union, use a double long splint with a transverse cross piece. In other cases a single long splint is

sufficient; with the double long splint the patient is fixed in a wooden box, so that he can only move his arms and his head.—*Edinburgh Medical Journal*.

THE TREATMENT OF GONORRHEA.—Seneca D. Powell, M. D., in Quar. Bul. N. Y. Post Grad. Med. School. By gonorrhea I mean any inflammation of the urethral tract which has been produced either by a specific poison or by the menstrual fluid, or by leucorrheal discharges, for I know of no way of distinguishing a urethritis which has for its origin either the one or the other of the above causes. And it matters not what the cause of the urethritis may have been, the fact remains that one is as contagious or virulent as the other.

In the first or introductory stage, if I am fortunate to see the patient at that period, I feel moderately sure of giving speedy relief. I begin the treatment by giving a free purgative, preferring those drugs which act upon the lower bowel rather than a saline cathartic. If the patient has not an excessively sensitive stomach, an emulsion of castor oil, combined with a small dose of spirits of turpentine, (3 i) acts well and thoroughly empties the entire tract. I also order two or three drachms of the bicarbonate of soda in Vichy, to be taken in the twenty-four hours. Even at this early stage I have found great benefit result from the frequent bathing the penis in very hot water. As an injection, a weak solution of the salicylate of soda, two to five grains to the ounce is used, but more frequently injections of hot water without any medication is preferable.

Injectations should be hot.

Latterly I have aborted gonorrheal attacks in the first stage in the following manner: After washing the urethra thoroughly with Harrison's urethral syringe, I introduce a rubber canula down below the seat of inflammation, and as I gradually withdraw it, fill the urethra with a dry powder made up of 3 i of resorcin and 3 i boracic acid, which is allowed to dissolve in situ. I repeat this each day if there be any discharge, but so far never have used it oftener than three times. If the urethra is comparatively dry the day after its application, a weak solution of sulphate of zinc, one grain to an ounce of hot water, is frequently used as an injection.

The patient is ordered to remain quiet, and if possible in bed, while the diet is cut down to milk and mush. The syringe which gives the most satisfaction is the small rubber syringe known as No. 1 a, and it is always best to have your patient thoroughly understand the proper man-

ner of using it, for I find very few who are proficient in this detail, although they, as a rule, claim to know just how it should be done. I prefer this style of syringe for several reasons :

The nib or point is very short and no injury to the sensitive and inflamed mucous membrane can result from its use ; and again the capacity is small, and there is less likelihood of the secretions being driven back into the urethra by a large volume of water. An injection ought always to follow urination if possible. Large quantities of Vichy or other waters should be taken, not only to dilute the urine, but also to facilitate the more frequent use of the syringe after urination.

The second or inflammatory stage follows quickly upon the first if we have been unsuccessful in aborting the disease. In this stage we should be extremely careful not to attempt too much, for I am positive that many of the cases which have come under my notice have been exaggerated, and much serious damage has resulted from unjustifiable interference by the patient, under the instruction of those whom he has consulted. If a patient comes to me with his penis swollen and engorged with inflammatory products, the lymphatics inflamed, and the glands in the groins painful and swollen, I make no effort at medication by the syringe, but treat the inflammation locally and constitutionally as I would were it in any other part of the body.

There is always more or less increase of temperature and quickening of the pulse, and I begin my treatment by giving the tincture of aconite, in two or three drop doses, combined with liq. ammon. acetatis, one to four drachms every two, three or four hours, as indicated. The penis is frequently immersed in hot water or wrapped in borated cotton, and kept wet with lead and opium wash. The amount of bicarbonate of soda and alkaline waters is increased, and the bowels relaxed with mercurial purgative. Just here let me speak of the use of saline cathartics : For several years I have avoided them religiously, for this reason : If there be extensive inflammation, and it goes well back in the urethra near to the neck of the bladder, the mucous membrane being very much thickened and the calibre of the canal lessened, there is, as a rule, more or less spasmodic retention of urine, and the administration of any saline cathartic will, in a great number of cases, increase this difficulty. I have seen this not once, but many times. Be as severe in your restrictions as possible, confining your patient to his bed if need be, and adhere firmly to your low diet. All exercise should be forbidden wherever possible. If it be absolutely necessary that your patient attend his usual duties, a well

adjusted support for the testicles should be ordered. Any further interference in this stage of the disease is in my opinion injurious, and especially would I avoid copaiba. It is not only useless, but I am positively certain, harmful—increasing the discharge, the ardor urinæ, and the painful erections; occasionally causing a very extensive and persistent rash, to say nothing of its effects upon an irritable stomach. When complications arise, one must be governed by circumstances. Usually the inflammation is modified in three to five days, the discharge decreases and becomes thicker in consistency, the color being whiter, the scalding upon urinating is gone, and the disease enters into the third stage or stage of subsidence.

A physician's assistance is oftener sought at this stage than in the first or second, as its period of duration is very much longer, and may extend over many months and even years; as in a case which recently came under my care, the discharge having lasted four years. Not until after all inflammation has subsided should we use injections otherwise than as I have cited. My first recipe, upon seeing a patient at this stage of the disease, is a good cathartic; and I usually select something mild and which can be repeated every day if necessary, such as rheum and soda, or compound liquorice, pulverized. I also direct the following injection to be used every two or three hours, if convenient: Zinc sulph., gr. viii; Morph. sulph., gr. iss; sodii bicarb., ʒss to ʒj; water, f ʒviij.

I restrict his diet to the plainest foods. No seasoning or condiments are allowed. Coffee and tea only in moderate amount and very weak. All kinds of liquors stopped, unless my patient is an habitual drinker and is very much dependent upon his daily dram for his usual appetite and digestion. Very moderate exercise is allowable; but the use of tobacco is entirely, or nearly so, prohibited. I see my patient within the twenty-four hours, and if there be no increase in the discharge or change in its character, and there are no evidences of increased inflammation, I begin the use of copaiba; and this I consider the only period wherein it is admissible. If the second stage has lasted any length of time, I much prefer cubebs, given in powder in ʒss to ʒj doses, three or four times a day. In other words, if the mucous membrane is changed from frequent attacks of clap or prolonged chronic inflammation, cubebs gives the best results. I have tried every drug suitable for an injection, and believe that sulphate of zinc ranks them all. Next in my estimation is tannic acid. I never use nitrate of silver in any form for an injection. It has proven unsatisfactory in my hands so often, that I have entirely

discarded it. Injections should not be strong enough to cause any pain, and are given not only for their astringent effects, but to keep the urethra clean—this being a very important adjunct, in my judgment. The lacunæ, especially the larger ones around the meatus, frequently give us a great deal of trouble by acting as pockets or hiding-places for the disease, and time after time it will spring up after ceasing the use of the syringe. I have in many cases passed a canula and rod armed with cotton saturated with the resorcin and boracic acid, as given before, and wiping the urethra thoroughly in its whole pendulous portion. The small granulations which are sometimes present are more rapidly removed in this way than even by the use of the sound.

I do not mean to imply, gentlemen, that this method of treatment is infallible, but I do say that it has given me more satisfaction and more rapid recoveries than any other.—*College and Clinical Record*.

ON A METHOD OF FORMING THE FENESTRA IN PLASTER-OF-PARIS BANDAGES FOR COMPOUND FRACTURES.—(Dr. R. W. Shufeldt in *New York Medical Journal*.) The following method of setting a compound fracture and making the fenestra can invariably be brought into play with the greatest success:

The bones of the fractured limb being properly approximated, and the limb itself extended and held by the assistants, the wound is first thoroughly cleaned and the limb lightly oiled. We then take a common, clean, cylindrical glass bottle, with a concave bottom, the diameter of its base being equal to the diameter of the fenestra we wish to form. The base of this bottle is next completely filled with a wad of absorbent cotton, and applied over the wound. This must be done by an assistant, and in such a manner that the centre of the base of the bottle and the wound are, as nearly as possible, opposite each other. The bottle is to be held in this position during the complete operation of applying the bandage.

The next step consists in enveloping the limb in a layer of absorbent cotton, carefully passing round the bottle when we come to it. This is held in place by the application of a *wet* three-inch roller bandage, which in turn *surrounds* the bottle when reached. In the usual manner we then apply the plaster bandages, surrounding the bottle as before in the case of the other layers of the dressing.

A few moments are sufficient to allow us to trim down such plaster as has accumulated about the bottle to a level with the outer surface of

the splint. This can best be done with a good strong knife-blade. The bottle can now be slightly turned and easily withdrawn, leaving, as it always does, the circular piece of antiseptic cotton covering the wound. With our knife we now nicely round off the edges of the fenestra before removing the cotton from over the wound, as it protects the latter from the *debris* of this part of the operation.

Finally, the cotton itself is carefully removed, and we see that it has taken up such discharges from the wound as have occurred during the application of the bandage, and we have before us as a result, not only our bandage safely on, but a fenestra with cleanly rounded edges, with its exact centre occupied by the wound.

PHYMOSIS.—(De Forest Willard, M. D., Lecturer on Orthopedic Surgery, University of Pennsylvania, etc., in Arch. of Ped.) An adherent and contracted prepuce is a normal state at birth in all male infants, or to speak more correctly, adhesion is always present with apparant contraction. True contraction is rare during early infancy, and the adhesion at this time is very slight. The latter becomes more firm with advancing years, but is usually relieved by the boy's own manipulations before he reaches the age of ten. The retention of smegma or a slight balanitis may also convert a seeming contraction into a true one. This retained smegma, as a rule, seems to result in no serious injury, but in a considerable number of cases the irritation produced by the hardened masses not only conduces to priapism, dysuria, symptoms of stone, cystitis, general mal-nutrition, and nocturnal incontinence, but also to paresis, chorea, convulsions, and various reflex nervous phenomena.

The long narrow foreskin of a child at first gives the appearance of contraction, but if the skin be gently and patiently pressed backward for a few moments the opening, almost a pin-hole at first, will be seen. As the prepuce recedes upon the stiffening member, the meatus will appear. Often the adhesion will be found to commence just behind this orifice, but no instrument other than the operator's thumbs will be required. The force requisite to peel off the rind of an orange will speedily strip the prepuce from the glans and carry it behind the corona, when the smegma can be removed and an emollient ointment applied. Restoration of the prepuce to its original position should be accomplished before turgidity of the glans occurs. In case of delay or difficulty, a couple of probes or hair-pins answer admirably for sliding the skin back into position.

The use of a probe or grooved director to tear up the adhesions is rarely though sometimes necessary. Dilatation by dressing forceps or special phymosis forceps is only occasionally required. Uterine dilators, tracheotomy forceps, and various forms of instruments specially constructed have been used for this stretching process, but as one increases in dexterity from practice he will find them of but little importance, as stripping by the thumbs is ordinarily easily accomplished. Slight edema, and painful micturition will follow this operation for a few days, but emollients are sufficient for relief. A hot hip-bath will greatly facilitate the passage of urine. Retraction and cleansing should be persistently employed thereafter, and the nurse instructed that daily attention is to be practiced. Later the patient should be taught to wash the penis just as he washes his face and hands for cleanliness sake.

There are many who deny that reflex phenomena are caused by phymosis, but the proofs are too positive to admit of disbelief, and Sayre deserves much credit for emphasizing the importance of this adhesion in the production of ataxic conditions. One may well differ from him as regards the remedial measures required, but not as to this causal element in muscular incoordination.

I have before contended and still maintain that the most perfect penis and the one least liable to disease or to induce masturbation is one in which the prepuce moves freely over a normal glans, and that this can be secured in nearly all young children by the simple stripping already described. In a few cases, when this result is not attainable, circumcision may become necessary; and when failure to produce the desired freedom occurs, I do not hesitate to practice the more severe operation. In large boys and in adults all the circumstances are different, and dilatation is rarely beneficial without removal of the foreskin; but in infants and in boys from two to eight one need rarely ask for better results than are secured by the thumbs alone.

Dr. Ellwood Wilson, who for many years has had one of the most extensive practices in this city, recently informed me that he had employed stripping of the glans since my recommendation of the operation in 1883, and that he has now acquired such dexterity of manipulation that he could uncover the glans in almost every young child without the use of any instrument. He now rarely resorts to circumcision, although he formerly practiced it largely. His experience coincides with that of all who have tried the plan. Until the surgeon has acquired this skill, it will be well for him to retract the fold as far as possible, and

while holding it firmly in this position to sweep a probe around the circumference of the head, thus loosening the anterior adhesions. Retraction, which before seemed impossible, will now be a simple matter, since it is the adhesions that produce the apparent contraction. The operation may be done as early as the second day of life.

The retention of the head of the organ beneath the foreskin is said to debar the individual from the full enjoyment of sexual intercourse in later years, but as there does not seem to exist any crying need for incentives in this direction, and as the obtunding influence of friction upon the exposed epithelium is similar in its action and especially as there is no need of any glans being covered provided early stripping is practiced, I still believe that a non-adherent prepuce is the healthiest condition. Moreover, a glans covered by a freely sliding foreskin is certainly better capable of appreciating the sexual orgasm than one that is calloused. Cold water used daily is also more helpful than circumcision in the prevention of disease.

It has already been stated that circumcision is occasionally necessary in children and frequently in adults. The rule should be to expose the glans freely for cleansing purposes whenever the slightest irritation arises. This condition should be secured by a cutting operation provided the simpler method fails. In skillful hands this will be at rare intervals, but when required in infants with excessively long and narrow foreskins, the removal of a ring is better than slitting up the fold, since thickened masses on either side of the frenum are liable to follow the latter operation and greatly disfigure the organ.

A large number of forceps have been devised for this particular operation, many of them ingenious and useful, but entirely unnecessary since a bistoury and forceps are equally good, and are always at hand. The section can always be made anterior to the forceps. Care should be taken in the ordinary circumcision to draw upon the mucous layer more strongly than on the skin, and thus remove a sufficient portion of the former, since if this is not done, slitting and trimming is necessary to remove the contraction, followed by careful stitching. Wire is no better than silk and is much more annoying and painful during the next few days. On account of the great edema of the loose connective tissue which is sure to follow, black sutures are more easily distinguished than white ones. In order to secure the most speedy union, the wound should be washed with a 1 to 5000 bichloride solution, and covered with a large wad of feebly sublimated cotton, which can be renewed at each

urination. The best bandage is an ordinary diaper. The vessels will rarely require either a silk or catgut ligature. Hemorrhage is rare. A fatal case is occasionally, however, reported. The stitches should be removed by the fourth day, and undue inflammation subdued by cooling lotions.

In summing up it can be said that stripping in young infants is one of the simplest and easiest of operations. In children it is still easily accomplished in the majority of cases by the help of a grooved director or probe. After twelve, if the glans has not been uncovered, circumcision will usually be necessary as dilatation is rarely successful in giving that freedom of motion which is essential in all cases.

Exposure of the glans is always necessary for cleanliness sake, and should be secured without fail whenever any nervous or reflex symptoms are present.

GLAUCOMA. Some very practical remarks of Dr. Javal on this subject will not be without interest for the general practitioner, for whom they were intended. "I desire to treat this subject for the reason that it seems well adapted to show the slight use there is in the pretended scientific exactitude which we eye-specialists sometimes are tempted to boast of. And I shall try to treat it in an elementary manner, though it is one of the most difficult subjects in ophthalmology. You know that this glaucoma in its advanced stage is characterized by an augmentation in the pressure on the eye, by a diminution of extent of the visual field, and by a weakening of sight, with conservation of the sense of colors. So that your smart specialist, after having examined the eye with his ophthalmoscope, hastens to measure the tension by means of the tonometre, the peripheric vision with his perimetre, and the color-sight by Wolfberg's method. I have all these things here; but what is the use of showing them to you? For, remark one thing at the commencement: at the period when it is important to establish the diagnosis, all this arsenal will not help you. The ophthalmoscope itself is of no use, for the famous excavation of the optic nerve so much spoken of does not come until later; and as for the pulsation of the central artery of the retina, it may fail you; and I have seen it also in a perfectly healthful eye. It is important that all should be able to recognize glaucoma from its beginning, for expectation is not permitted in this trouble, and *the instillation of a single drop of atropine can produce an irremediable aggravation in an eye affected with glaucomatous prodroma.* And I will add here

something quite new for you : which is that cocaine can produce just as bad effects in these eyes, notwithstanding the diminution of pressure that follows its use.

Diagnosis. How will you know glaucoma? For those eyes that are hard to the touch and have perikeratic injection, with a pupil immobile and the cornea dulled and painful, you don't need even the ophthalmoscope; but it is great art to catch them before this. The history mostly is that for months, or even years, the patients find a slight loss of vision in obscurity, and he finds that in the evening there is a halo around the lights. If you are consulted by a person complaining of a loss of vision that has come on rapidly, and you see the slightest inequality in the pupils, the slightest weakness of the sphincter of the iris, be careful and don't put either atropine or cocaine in the eye; also don't forget that an eye with glaucoma is not always hard. The halos spoken of are an important symptom. They will see them mostly when a match is struck in the dark; but these halos may occur in other eye-troubles. In this case you have only to instill a little eserine in the eye, and if they disappear your diagnosis is fixed; and it is to this medicine that you must look to help you in this disease at first. The wholesale druggists now manufacture little gelatinous rings of eserine, each containing the one-hundredth of a milligramme of the drug. These you may give to your patient, and if two of them a day do not relieve the symptoms, then surgical interference is called for. I need not say that all alcohol must be stopped, and but little meat allowed, and that well masticated. This, with plenty of out-door exercise and clothing very loose, constitutes the hygienic treatment.

Operative Treatment. If, with all your care, it continues, don't delay the operation. Sclerotomy should never be thought of. *Iridectomy is the operation*; and I presume that you will not care to perform it yourselves, although it is not so difficult with the aid of cocaine, which may be used only when followed by an operation. But there is one thing you can and should do, and that is when you find yourself in presence of an acute glaucoma, when moments are precious, practise a *debridement* of the globe near its equator, between the rectus internus and rectus inferior muscles. A bistoury-cut of a few millimetres, as recommended by M. Parinaud, will often give immediate relief, and allow you the time to take the patient to some specialist to have a good iridectomy performed.

"To sum up: *Abstain from atropine and cocaine, and use eserine in the first symptoms of glaucoma, and in case of acute glaucoma don't hesitate to debride the ocular globe.*"—*Med. Times.*

OBSTETRICS.

A FEW SUGGESTIONS FOR THE PREPARATION OF MILK FOR INFANTS.
By John M. Keating, M. D., in the *Medical News*.

At the recent Sanitary convention of the Pennsylvania State Board of Health, I advocated the use of cow's milk prepared so as to resemble closely woman's milk as the best form of diet for at least the first three months, urging at the same time that a certain amount of a soluble salt of lime should always be added to an infant's food to counteract the great tendency to rickets which exists in all bottle-fed, and, indeed, in many of the nursed children of the day.

Let us take one of the given analyses (Percy) of cow's milk, that of an ordinary mixed dairy :

Water.....	86.67
Butter	3.20
Sugar	4.20
Casein	5.30
Salts.....	0.62

If this is diluted with *three* times its bulk of water, it will give us the following :

Water.....	96.70
Butter.....	0.80
Sugar.....	1.05
Casein.....	1.33
Salts.....	0.16

There seems to be some difference of opinion in regard to the quantity of casein and sugar (per cent.) in human milk. In every young infant it is better to have the minimum quantity as a basis to begin with, so that by diluting the milk as above we reach, accurately enough for practical purposes, the percentage as given by A. V. Meigs, viz :

Water.....	87.16
Butter	4.28
Sugar	7.40
Casein.....	1.04
Salts.....	0.10

If to a *four* ounce mixture composed of *one* ounce of ordinary milk and *three* ounces of water, we add *one* ounce of ordinary cream (about fourteen and a half per cent. of butter), and about eighty grains of sugar

of milk (a level teaspoonful and a half)*, we will get a result which closely resembles woman's milk, though containing less casein and more sugar than most authorities give as the result of their investigation. Still, for very young infants this is an advantage rather than otherwise. As the child grows older, say two or three months, the amount of casein can be increased as follows :

Take *two* ounces of ordinary fresh milk, and *two* ounces of water; the following will be the result :

Water	93.38
Butter.....	1.60
Sugar.....	2.18
Casein.....	2.65
Salts.....	0.31

Now, add two tablespoonfuls of ordinary cream of good quality and a heaping teaspoonful (about 100 grains) of milk sugar. Cream itself contains about three per cent. of caseine. But I have insisted that there must be a certain amount of lime added to the mixture, and I do not think that lime-water always serves the purpose required, even if it be given in large amounts. I prefer the soluble *lactophosphate*, and have used it largely with success for some years. To make this matter simple and to facilitate the carrying out of instructions, I have had compressed *tablets* (*Milk Food Tablets*) made, each containing :

Sugar of milk.....	26 grs.
Calcis loctophos.....	1-6 gr.
Calcis. carb.....	1-12 gr.
Sodii bicarb.....	1-2 gr.
Potass. bicarb.....	1-12 gr.
Sodii chloridl.....	1-6 gr.

These are to be used as follows:

To prepare the bottle for a child about a month old or younger, take three ounces of boiling water and stir in one ounce of ordinary milk; to this add three tablets and dissolve thoroughly; place the mixture in a nursing bottle and add two tablespoonfuls (one ounce) of good, fresh

*A silver teaspoon, such as is in ordinary use, when filled with sugar of milk and "leveled," will contain about fifty-seven grains; a plated teaspoon contains about five grains less—practically 5j. A silver teaspoon when "heaping" holds about 117 grains of sugar of milk—practically 3ij.

cream ; shake well, and give to the child at about the temperature of the body.

For a child two or three months old, take two ounces of water (boiling) and stir it into two ounces of good, fresh ordinary milk (if the child is of a constipated habit, they need not boil together) ; then dissolve into the mixture four tablets, pour this into the nursing bottle, and add one ounce of fresh, ordinary cream ; shake well.

If the child's stools contain a mass of curds, showing deficient digestion, it would be well at once further to dilute the milk. Should this not be sufficient a small quantity of malted food, such as Mellin's or Horlick's, a teaspoonful to the bottle, can be added to stimulate the digestive functions. If this fail, then use *peptogenic* milk powder, and predigest the curd ; and, finally, if still unsuccessful, put the child on condensed milk.

UTERINE HEMORRHAGE, STRYCHNINE IN.—In a communication to the *British Medical Journal*, Dr. L. Atthill says: For many years I have been in the habit of administering strychnine in combination with ergot in the five following classes of cases:

1. Where, from previous experience, I had reason to anticipate the occurrence of *post partum* hemorrhage.

2. Where, during the progress of a tedious labor, the uterus becoming exhausted, I had reason to believe that hemorrhage would follow on delivery.

3. In cases of menorrhagia depending on imperfect involution of the uterus.

4. In certain forms of hemorrhage caused by the presence of uterine tumors.

5. In some forms of amenorrhea.

In the first class of cases, I generally commenced the treatment three weeks before the expected advent of labor. If the patient was anemic, I combined the strychnine with iron ; if plethoric, with muriatic acid ; in all cases, the vehicle being the infusion of ergot ; and I have had the most satisfactory results. After the patient had taken the medicine for a week or ten days, I discontinued its use for forty-eight hours, recommencing it again. In several cases in which the patient had invariably suffered, previous to the adoption of this treatment, from severe *post partum* hemorrhage, none occurred ; in all the others, it was markedly less. I never once have known any unpleasant results follow ;

in none was the fetus affected, all the children were born alive, and, as far as I know, none suffered from convulsions subsequently. I may here add that I believe ergot to be absolutely innocuous to fetal life, unless it produces its specific effect, that is, excites almost continuous uterine action; and my firm belief, founded on a very extended experience, is that ergot is powerless to originate uterine action; it will stimulate an uterus previously in action, or one in which uterine action is about to commence, as in the case of a uterus containing a blighted ovum or foreign body; but not, as far as my experience goes, under any other circumstances, and not always under these. The formula I generally use is the following: Infusi ergotæ ad ℥ vj; ext. ergotæ liq. ℥ ij; liq. strychniæ ℥ j; acid. hydrochloric dil. ℥ ij. A tablespoonful, by measure, three times a day. In anemic cases, substituting a drachm of the ammoniocitrate of iron for the muriatic acid.

With respect to the second class of cases, ergot here is still more unreliable than in previous class of cases; strychnine promises better results. I generally combine it with ergot, giving ten drops of the liquor strychniæ (*British Pharmacopeia*) with the first dose, and five with a subsequent one, if necessary. I can confidently recommend this combination.

In conclusion, that strychnine exerts a direct action on the uterus, is to my mind clearly established. Added to ergot in cases of parturition it greatly increases the efficacy of that drug, being specially useful when *post partum* hemorrhage is anticipated. It appears to have the power of increasing the tonic contraction of the uterine fibers, and of preventing their undue relaxation when the pain has subsided. It is specially valuable, administered in combination with ergot, in cases of menorrhagia depending on imperfect involution of the uterus. Its use is contra-indicated in all cases where any inflammatory condition of the uterus or ovaries exists. Strychnine is also useful in many forms of amenorrhea, where it seems desirable to stimulate the uterus and ovaries; and in such cases it is often prescribed with advantage, in combination with iron. It should be administered cautiously, commencing with three or four drops of the liquor; the dose to be gradually increased to eight or even ten three times a day. I have, however, known even small doses produce very unpleasant symptoms, some patients being apparently very susceptible to the effects of the drug.—*Arch. of Gynecology*.

THE INFLUENCE OF DIABETES ON GESTATION, PARTURITION, AND MENSTRUATION.—According to many authors, diabetes renders women

sterile. Six cases studied and treated by Dr. Lecorche contradict this theory. His six diabetic patients were delivered of children at term, but they were all delicate. One child died two days after its birth; another when 21 months old, became hydrocephalic, with polydipsia. There was no sugar in its urine. A third had a double hydrocele, and was also hydrocephalic, and could not live. Dr. Lecorche concludes that diabetes does not render women sterile. When they do not conceive, it is uterine lesions, resulting from diabetes, that cause their sterility. Diabetes has direct influence on the process of gestation, impairs fetal nutrition, and is favorable to faulty development, especially hydrocephalus. Diabetes often produces dysmenorrhea and amenorrhea. Early menopauses may result from an overlooked diabetes. The menses may reappear when the sugar disappears. According to Dr. Lecorche, metrorrhagia in a diabetic patient indicates a coexistent uterine affection, and is not the result of diabetes.—*Brit. Med. Jour.*

CLIMACTERIC DIABETES IN WOMEN.—Lawson Tait, F. R. C. S., etc., in the *Practitioner*, thus concludes: Roughly speaking, the conclusions that I have arrived at concerning this affection are that in the great majority of cases of eczema of the vulva at the climacteric period, the disease is due to the presence of sugar in the urine. I have not yet come across a case of this kind in which, having examined for sugar, I have not found it. The disease seems to begin at or near the arrest of the menstrual functions and to extend over a period of several years, then terminating in all probability by nature's own process. The sufferings of the patient are very much diminished, and probably the duration of the disease is shortened by the liberal administration of opium; whilst the local trouble is best mitigated by ointments containing such substances as will arrest the process of fermentative change in sugar. So far the best substance that I have found for the purpose is the old-fashioned hepar sulphuris.

TREATMENT OF THE HYSTERICAL ATTACK.—Dr. Albert Ruault gives a simple method which he has found very efficacious in controlling an hysterical fit. It consists in making firm and constant pressure over the supraorbital nerve at its point of emergence from the supraorbital foramen. The head is held securely between the palms of the hands, while pressure is made over the nerve on each side with the thumbs. The writer says that the patients under this treatment first contract the facial muscles with an expression of pain, cry out, and then take several quick successive inspirations. The breath is held for a few seconds, and

then, with a long expiration, the muscles relax and the attack is ended. The pressure of the thumb should now be relaxed, otherwise it may have the opposite effect and excite another convulsion. Pressure over any nerve-trunk at the point where it becomes superficial will have the same effect; but the supraorbital nerves are chosen because of their convenient situation.—*France Medicale*.

STAFFORDSHIRE KNOT.—Mr. Tait makes the tie to constrict a pedicle in two equal parts, as follows: He employs an awl-like needle, with an eye near the point, and threaded with the ligature, to transfix the pedicle at its middle. As soon as the eye appears on the distal side, the ligature is seized and pulled upon while the needle is withdrawn, and entirely cleared. Now there is a loop on one side of the transfixed pedicle and two free ends on the other. The next step is to pull upon the loop until it is long enough to pass over the tumor or collapsed ovarian cyst; then one of the free ends is passed through the loop, and the two ends pulled upon till the loop is shortened and made to encircle the halves of the pedicle at the line of transfixion.—*Albany Medical Annals*.

THE MEDICO-LEGAL SIGNIFICANCE OF HEMATOMA OF THE STERNO-CLEIDO-MASTOID IN THE NEWBORN.—In an elaborate article in the *Centralblatt f. Gyn.*, Kustner presents the following conclusions:

1. Hematoma of the sterno-cleido-mastoid is not a result of extension or stretching, but of torsion of the neck.
2. Inasmuch as severe torsion of the neck may occur in spontaneous delivery, and in foot or breech as well as in head presentations, hematoma also may occur under these conditions.
3. Hence it is not permissible to conclude from the existence of a sterno-cleido-mastoid hematoma that manual or instrumental aid has been applied in the delivery.

COLUMBUS MEDICAL JOURNAL.

EDITORIAL.

Heating and Ventilating.

The connection of the heating of a house with its ventilation is, of course, inseparable. Many persons will cheerfully expend ten or fifteen thousand dollars in building a house, putting from two to three thousand on outside ornaments, who would not dream of spending five hundred or one thousand dollars for the necessary Hot Water Apparatus to keep this same house thoroughly and comfortably warmed and well ventilated.

In reading the reports from the various Boards of Health, one can not fail to notice the startling increase in the death rate from Scarlet Fever, Diphtheria, and allied diseases. It might safely be said that this condition of affairs is due to the fact that the tightly closed doors and windows, which cold weather makes necessary, prevents the ventilation of houses, which is essential to the maintenance of health.

To those who intend erecting a dwelling, we would advise that the matter of heating and ventilating be given much consideration; and before deciding how it shall be done, consult the A. A. Griffing Iron Co., Manufacturers of the Tompkins Hot Water Indirect Radiator, 518 Communipaw Ave., Jersey City, N. J.

Fluid Forms of Hydrastis.

The reputation of this drug as a therapeutic agent was first gained through its employment in the form of an *infusion*; and in the fifty years following its introduction into medical practice, a continuous effort has been made by manufacturers to perfect a preparation which would represent all the active principles of the drug, without the high price of the salts, either alone or in combination.

The most prejudiced writers on *Materia Medica*, accord to the late Wm. S. Merrell the largest share of credit in the introduction of Hydrastis preparations, and to the present organization the reputation of being the *largest consumers of the drug in the world*. For more than a half-century, Hydrastis has been made a study in our laboratory, and we do not think we exaggerate its importance when we assert that it stands pre-eminent to-day as the most valuable exponent of our vegetable *Materia Medica*.

The following preparations in *fluid form* are receiving our special attention at this time:

Fluid Hydrastis—MERRELL.

Is what its name implies—the active, medicinal principles of the drug in natural combination and in a fluid form. It has a bright, yellow color, perfectly clear, free from sediment, and with an unmistakable odor of the *fresh drug*.

Fluid Hydrastis is a pure, neutral solution of all the alkaloidal constituents of the drug, rejecting the oil, gums, irritating and offensive resins and inert extractive matters. The success attending its introduction is the best evidence of its therapeutic value.

Unsuccessful imitations and would-be substitutes are met with on every hand. Preparations said to be “just as good” or “about the same thing,” but always “a little cheaper,” attest the wide-spread and growing popularity of Fluid Hydrastis. All such, compared with the latter as to physical appearance or as representatives of the drug, *are condemned*; dispensed in prescriptions, *they are readily detected*; tested therapeutically, *they are promptly rejected* as unworthy of confidence.

Fluid Hydrastis is applicable to the treatment of all irritable, inflammatory and ulcerative conditions of the mucous tract.

This statement of a well-known medical writer and journalist has become axiomatic:

“No remedy for physician's use has been received with such universal approval.”

Solution Bismuth and Hydrastia—MERRELL.

An invaluable and scientific combination, wherein the beneficial action of the white alkaloid is increased by association with Bismuth. This solution contains $2\frac{1}{2}$ grains of the double Citrate Bismuth and Hydrastia; twenty-five per cent. of which is Hydrastia Citrate.

The cordial reception accorded this preparation marks it as the most valuable combination in the market in which the white alkaloid alone represents the valuable properties of the drug. Used in diseases of the nasal passages, of the eye, of the throat, of the stomach and intestines, of the reproductive organs and bladder it is equally beneficial.

Colorless Solution of Hydrastia—MERRELL.

This is a permanent solution of the white alkaloid, without the addition of any other medicinal agent to modify or increase its action. It is offered without special recommendation to meet the views of an unlimited number of physicians, with whom the color of the Fluid Hydrastis is an objection. This solution contains in one fluid pint the same proportionate strength of white alkaloid as exists in an average quality of crude root.

See notes above on Solution Bismuth and Hydrastia.

“Merrell's Hydrastis Preparations” are for sale by Wholesale Druggists throughout the United States. Please Specify “Wm. S. M. Chem. Co.” in ordering or prescribing.

THE WM. S. MERRELL CHEMICAL CO..

CINCINNATI.

ORR, BROWN & PRICE and BRAUN & BRUCK, Columbus, Wholesale Agents.

EDITORIAL DEPARTMENT.

J. F. BALDWIN, M. D., Columbus, - - - EDITOR.

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HANN & ADAIR, Publishers, Columbus, O.

STATE BOARD OF HEALTH. The Board seems to have been fortunate at last, in their selection of a Secretary. Dr. C. O. Probst, although he has held the office but a very few weeks, has already shown himself admirably fitted for the position. Although the law, under which the Board acts, is very inefficient, the system of reports is much better organized than would have been expected, the last weekly report being based on returns from eighty-nine observers in fifty-one counties.

Of course only a beginning has been made in the work, but in this case, as in many others, it is true that "well begun is half done." We are, however, sorry that, owing to the resignations of the two first elected secretaries, the Board will not be able to make quite as good a showing in its annual report as it would otherwise have done.

MEDICAL INCOMES IN CANADA. The *Toronto Globe* (quoted by the *New York Medical Journal*) says: "There is only one medical man in this city who last year earned \$5,000 from his profession, combined with the interest he received on his previous savings. There is not one man on the list who had \$4,000, and only four who touched \$3,000. When we come to the comparatively modest and moderate \$2,000, we naturally conclude that we shall have a full legion. But no, we have only fourteen all told who come up to this figure. When we come to between \$2,000 and 1,000 the number becomes encouragingly large. As many as fifty-one of the best-known and greatly sought-after doctors of our city are put down under their own hands and seals as having last year lived on from \$1,000 to \$1,800. Some of these are professors. There remain

only the unfortunates who worry along with from \$800 down almost to zero. Of these, we are sorry to say, there were last year thirty-six."

Toronto is a city of 120,000 inhabitants. That professional incomes there should be so much less than in the United States, seems strange. Professional jealousy is usually so great as to scarcely warrant the suspicion that the above returns were made—like those in Ohio of personal property—with a mental reservation, to save taxation: we have even heard of physicians, during the days of the "income tax," who were only too willing to be taxed on several thousand dollars more than their actual incomes, for appearance's sake.

As this explanation, then, is not tenable, we must either accept this great difference as an unexplained fact, or else fall back on the assumption that most of the reported incomes in the States are grossly exaggerated. Our readers must accept whichever solution they please.

JEFFERSON MEDICAL COLLEGE has recently been receiving considerable adverse criticism from the medical press. A part of this criticism is just, but much of it we think is entirely unmerited. That Jefferson has failed to adopt the three years' course of instruction, that she has instituted no entrance examination, that her faculty is relatively small, and that her final examinations are such as to be easily passed by nearly every applicant, are matters worthy of criticism; but that the recent resignations of one professor and two lecturers were due to causes incidental to the forthcoming International Congress, we do not believe, and can not but feel that all criticism based on that supposition is unjust and undeserved. We may be in error, but such is our conviction.

A PROPOS of the above, the newspaper readers of Columbus have recently been regaled with a species of controversy, in which the Dean of Jefferson took a prominent, but far from dignified, part. The whole matter was briefly as follows:

July 14, the Board of Health of West Virginia, for satisfactory reasons, refused to register diplomas from Jefferson. This fact was telegraphed, by the Associated Press, all over the country, and published in the papers of July 15. July 16, an article appeared in a local paper, in which the writer not only endeavored to make capital out of this action of the Board, in favor of a local school whose diplomas were "black-listed" by the Board some years ago, but also made personal and offensive allusions to a local physician who graduated from Jefferson a dozen years ago. In replying to this attack, the physician alluded to

made some incidental remarks in regard to Jefferson which, while true, were not complimentary to that school. A few days later this same physician, having learned from private sources that the West Virginia Board had, on July 15, rescinded its action of the day before in regard to Jefferson, made known that action in the local paper. A week or so later, viz., August 2nd, Dr. Bartholow, Dean of Jefferson, came out, in the same newspaper, with a paid article, over a column in length, devoted about equally to a personal attack on the critic alluded to, and to an *ad captandum* puff of his school. In this article, Dr. Bartholow, by a skillful *misplacement* of quotation marks (he long since acquired a lasting reputation for his skillful *omission* of quotation marks), manages to wax very facetious over what he pretends to regard as the disappointed ambition of the critic; but those who are at all familiar with the state of affairs in Philadelphia, will readily read between his lines, and will easily see that he is really making a covert attack on those who have recently organized the Medico-Chirurgical College, have placed it on a firm basis, and are already drawing largely from Jefferson's supplies. It is these "mutual admiration sufferers," as he styles them, whom he fears and hence seeks to ridicule, and not the obscure critic who happened to furnish him with the long-sought pretext for his attack.

The critic made a short and plain reply to the Dean, the next day, in which he reiterated, extended and more fully elaborated his criticisms; but to this Dr. Bartholow made no response: he had no occasion to, as his purpose was fully accomplished, *i. e.*, he had secured a first-class *ad.* of his school, coupled with a vicious assault on its rival, for general circulation. And he has since actively circulated it.

CLINICAL FACILITIES OF COLUMBUS. The outlook for hospital instruction for medical students during the coming winter in this city is not so good as usual. St. Francis Hospital, with its capacity of one hundred and fifty beds, will, of course, be accessible, as usual, to the students at Starling, but the penitentiary hospital—which has heretofore been the only other source for such instruction—is now in the hands of the homeopaths, while the much announced Hawkes' hospital, which has at last been built, turns out to be only a small *pay* hospital, almost exclusively devoted to private patients.

INTERNATIONAL MEDICAL CONGRESS. There is but little new to be said as to the affairs of the Congress. It is pretty generally conceded that it will be largely attended by American physicians, so as to be ac-

counted a numerical success. It is about as generally conceded that it will not be very well attended by physicians from abroad, although N. S. Davis, Brodie, Pancoast, and several others, are now in Europe trying to secure promises of attendance. Just how successful this new species of "drumming" will be, remains to be seen.

"Circular No. 2," which we have just received, containing the names of the officers of the Congress, as at present arranged, contains very few names of eminent American physicians. This is to be greatly deplored, as we had hoped that some steps would be taken to secure the needed co-operation of these men. But mediocrity seems still to control.

MONUMENT TO DR. RUSH. We are in receipt of a circular signed by Albert L. Gihon, Geo. H. Rohe and Joseph M. Toner, asking for contributions to a fund for the erection, in Washington, D. C., of a statue of Dr. Benjamin Rush. The statue is expected to cost about \$40,000, and *dollar* subscriptions are called for. The following named physicians will act as treasurers of the fund for the States named, viz: Ohio, George A. Collamore, Toledo; Michigan, George E. Ranney, Lansing; West Virginia, S. L. Jepson, Wheeling; Indiana, J. H. Davisson, Warsaw; Illinois, S. J. Jones, Chicago; Kentucky, Steele Bailey, Stanford.

NEW MEDICAL SOCIETY. Twenty-one of the leading physicians of Adams County, Ohio, met at the Court House in West Union, June 17, 1886, and organized the Adams County Medical Society by the election of the following annual officers, viz: President, Dr. David Coleman; Vice President, Dr. C. W. Saisbury; Secretary, Dr. J. W. Bunn; Treasurer, Dr. C. S. Corboy. The next meeting will be held October 21st, at the above place.

THE FORUM. This is the best Journal of its class that comes to our table. The *Albany Argus* says of it: "No magazine, we believe, has ever before presented in so short a time so much valuable literature;" and the *New York Mail and Express* says: "It touches upon a greater number of subjects of popular interest and instruction than can be found in any other periodical that has yet been published in this country."

It has just completed its first volume—six months. Price per annum, alone or with the JOURNAL one year, \$5.

THE Kentucky School of Medicine presents its card to our readers in this issue. Young men contemplating a summer course of lectures would do well to correspond with the dean.

OBITUARY. Professor Frank Hastings Hamilton, M. D., died at his home in New York City, August 11th, in the seventy-third year of his age. He had been suffering with pulmonary disease for several years. He retained his intellectual faculties until the last. He was born in Wilmington, Vermont, September 10, 1813, and graduated at the University of Pennsylvania in 1833. Upon the organization of the Buffalo Medical College in 1846, he was made professor of surgery and held this position until November 28, 1858, when he accepted the professorship of the principles and practice of surgery in the Long Island College Hospital and removed to Brooklyn. In April, 1861, he became professor of military surgery, fractures and dislocations, and professor of clinical surgery in the Bellevue Hospital Medical College. He remained in these positions until May, 1868, when he was made professor of the principles and practice of surgery, with operations, and continued in this capacity until 1875, when he resigned.

During the war he rendered important service as Military Inspector. When President Garfield was shot Dr. Hamilton was called with Dr. Agnew for consultation and advice, and was associated with the case until the President's death. As a writer on medical subjects he was voluminous, learned, and an accepted authority. Among his best-known works are his treatise on "Fractures and Dislocations," and his "System of Practical Surgery," a new edition of which has just been issued.

Among the honorary positions which he held at various periods may be mentioned President of the Medical Society of the State of New York; President of the New York Pathological Society; President of the Medico-Legal Society; a founder of the New York State Medical Association; Consulting Surgeon to Bellevue Hospital and the Hospital for the Ruptured and Crippled; St. Elizabeth Hospital and the Bureau of Medical and Surgical Relief for the Out-Door Poor, besides membership in numerous medical societies.

He was married in 1834 to Mary Virginia McMurtan, of Virginia, and in 1840 to Mary Hart, of Oswego, New York, who died about a year ago. Two children, Theodore B. Hamilton and Mrs. Daniel Davis, survive him.

NEW FORMS OF MEDICATION. Our readers will be interested in investigating the merits of the new form of administering medicine, just introduced by Frederick Stearns, of Detroit. See his card on adv. page twenty-two.

CONVENIENT TEST FOR ALBUMEN. Dr. G. P. Best, in the *British Medical Journal*, advises the use of a syringe with air-tight piston, to draw up a little of the urine; the syringe is then transferred to the nitric acid, and a small quantity of it is sucked up. This, if albumen be present, gives the well defined ring between the two layers. The urine, if necessary, may be filtered previously.

AS MUCH flour as can lie on the point of a table knife, is more nutritious than eight quarts of the best Bavarian beer.—*Liebig*.

THE Iowa State Board of Health will not recognize the diplomas of schools who graduate over forty-five per cent. of their matriculants. At its late meeting, the Board refused recognition to nearly one hundred medical colleges.

REVIEWS AND BOOK NOTICES.

A Manual of Practical Therapeutics, Considered with Reference to Articles of the Materia Medica. By Edward John Waring, C. I. E. M. D., F. R. C. P., London; Surgeon-Major (Retired) in Her Majesty's Indian Army. Edited by Dudley W. Buxton, M. D., B. S. Lond, M. R. C. P.; Assistant to the Professor of Medicine at the University College, London, etc. Fourth Edition. Philadelphia: P. Blakiston, Son & Co. 1886. Columbus: A. H. Smythe. Cloth. Pp. 666. \$3.

The first edition of this work appeared thirty-two years ago, and achieved a wide reputation. This edition has been thoroughly revised and largely re-written. Much pains has been taken to include all the new remedies, and to retain, in every respect, the eminently practical character of the former editions. There are many features which render this work on Therapeutics especially valuable, as is shown by the great favor with which the former editions were received.

The Genuine Works of Hippocrates. Translated from the Greek, with a Preliminary Discourse and Annotations. By Francis Adams, LL., D., Surgeon. Volume II. Being Volume VII. of Wood's Library for 1886. New York, William Wood and Company.

We spoke so highly of this work, when noticing the first volume, that we need add no further word of commendation.

Medicine of the Future. An address prepared for the Annual Meeting of the British Medical Association in 1886. By Austin Flint (Senior), M. D., LL. D. 8vo; pp. 37: \$1. D. Appleton & Co., New York, 1886. Columbus: Geo. H. Twiss.

Our readers are familiar with the history of this paper, which was found complete among the author's papers at the time of his death. It is published just as written. It is presented on heavy, tinted paper, elegantly finished, and constitutes a souvenir volume. A fine portrait of the author is inserted.

Diseases of Digestion, Urinary and Generative Organs. Illustrated by one hundred and six fine wood engravings. Being Volume II, of the Handbook of Practical Medicine. By Dr. Hermann Eichhorst, Professor of Special Pathology and Therapeutics and Director of the University Medical Clinic in Zurich. This is Vol. VI. of Wood's Library for 1886. New York, William Wood and Company.

The favorable impression created by an examination of the first volume, continues with the second. The author devotes much more space to a consideration of the therapeutics of the diseases than is customary with Germans. Perhaps a reaction is setting in.

A Manual of Dietetics. By J. Milner Fothergill, M. D., Edin, Physician to the City of London Hospital for Diseases of the Chest (Victoria Park). Hon. M. D. Rush Medical College, Chicago, Ill., Foreign Associate Fellow of the College of Physicians, Philadelphia. 8vo, extra muslin. 255 pages. Price, 2.50. New York, William Wood and Company.

This is a most excellent book—one of the best, if not the very best, from the pen of the author.

Dr. Fothergill's strongest point is his knowledge of physiology, and physiology is the foundation of this book. The first hundred pages are devoted to the description and methods of preparation of food: the rest to the kind of food specially adapted to the various conditions, circumstances and diseases of humanity. It is a book which every physician, and every intelligent layman, would be the better for reading.

A System of Practical Medicine by American Authors. Edited by William Pepper, M. D., LL. B., Provost and Professor of the Theory and Practice of Medicine and of Clinical Medicine in the University of Pennsylvania, assisted by Louis Starr, M. M., Clinical Professor of Diseases of Children in the Hospital of the University of Pennsylvania. Volume V: Diseases of the Nervous System. Royal 8vo, pp. 1326. Philadelphia: Lea Bros. & Co. 1886.

The editors, and the publishers as well, may justly feel proud as they look upon this completion of their task. The work has been issued promptly, and every writer has done his part to add to the completeness of the whole. We might, perhaps, pick out some especially valuable portions, but such a distinction would be invidious where all are so excellent. The number of articles in the system is 185, written by ninety-nine authors, and covering 5,600 pages.

This volume, which completes the work, is devoted exclusively to the diseases of the nervous system. All the articles are from the pens of men recognized as exponents of this division of medicine. It is illustrated with fifty-eight cuts, the majority of which are original.

Taking a view of the volumes together, we can justly say, in the language of another, "Pepper's System of Medicine is a work that can ill be dispensed with, and the physician is unfortunate who can not, and unwise who will not, add it to his library."

A Manual of Surgery. In Treatises by various authors. In three volumes edited by Frederick Treves, F. R. C. S., Surgeon to and lecturer on Anatomy at the London Hospital. Vol. I., General Surgical Affections, The Blood-Vessels, The Nerves, The Skin. Vol. II., The Thorax, The Organs of Digestion, The Genito-Urinary Organs. Vol. III., The Organs of Locomotion and of Special Sense, The Respiratory Passages, The Head, The Spine. Duodecimos, 1866 pages, 213 engravings. Per volume, cloth, \$2. Philadelphia, Lea Brothers & Co., 1886.

This manual is not designed to be an exhaustive treatise on surgery, but to give to the practitioner and student a concise account of the facts and principles of modern surgery. Technical details, except as they concern special operations, are omitted, as also all of pathology, except its clinical aspects. These omissions, therefore, give ample space in the small volumes for the consideration of the clinical, diagnostic and therapeutical aspects of the subject. Although the volumes are small enough to be easily carried, as when one is going to a tedious case, they by no means belong to the "vest-pocket" series.

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No. 4

COMMUNICATIONS.

THE VISUAL FIELD AS A DIAGNOSTIC SYMPTOM.

BY B. L. MILLIKIN, M. D., CLEVELAND, O.

A paper read before the Ohio State Medical Society, June, 1886.

The field of vision is a subject so little studied and, withal, I believe, so important, that I may be pardoned for calling the attention of the Society to it for a few minutes. As a diagnostic symptom the field of vision is important, first, in local diseases of the eye, and second, in general diseases, especially those of the brain and spinal cord.

You all know the visual field is based upon the perceptive qualities of the retina outside of the macula lutea, and this perceptive sensitiveness diminishes as the periphery of the retina is approached. Consequently, whatever diminishes or destroys the integrity of the retina, or the optic nerve, must manifest itself by changes in the function of that membrane, and, as a rule, these changes are first perceived in the loss of function at the periphery of the retina, this portion being the least sensitive.

A few words as to the method of taking the field may not be out of place. It is sufficient in some cases, in order to get merely the objective field, to cause the patient to fix the finger of one hand, while with the other we ascertain the distance from the fixation point, in all directions, at which he can see to either count fingers, or see their motion.

Another means is to move a lighted candle, in a dark room, about the periphery of the field, the eye at the same time fixing a second candle. This is a useful way in determining the perceptive field in cases of cataract. But for the more accurate determination of the field, especially for that of colors, we must resort to one of two methods, either the use of the blackboard, or the perimeter. Generally the blackboard will answer all purposes, especially for mapping out the field within 45 degrees of the center, or macula, and for central scotomata. Outside of 45 degrees, however, it is not reliable.

The physiological field of vision may vary much in different persons, but from an examination of a large number of persons Augstein gives these as the mean limits :

	White.	Blue.	Red.	Green.
Outward.....	90°	80°	65°	50°
Outward and up.....	70°	60°	45°	40°
Upward.....	50°	40°	33°	27°
Upward and in.....	55°	45°	30°	25°
Inward.....	60°	45°	30°	25°
Inward and down.....	60°	50°	35°	27°
Downward.....	72°	58°	45°	30°
Downward and out.....	85°	75°	55°	40°

A variation of 5 degrees, or even 10 degrees, from this may not necessarily be pathological.

Pathological conditions, as indicated in the field of vision, manifest themselves in three ways :

1. By scotomata, or blind spots, in various portions of the field.
2. By alterations in the color field.
3. By concentric limitations of the objective field, either regular or irregular.

These modifications may occur singly or combined, and to each of these variations is attached a special significance.

Scotomata are blind spots which may occur in any portion of the field, very often being central. They are due to loss of function of certain nerve fibres of the retina or optic nerve, and occur in hemorrhages in the retina, detached retina, choroido-retinitis, from any cause, in what is known as tobacco amblyopia, where there is a retro-

bulbar neuritis with destruction of the optic nerve fibres which terminate at or near the macular region.

Another very important set of cases, in which a partial central scotoma for red is present, and which gives us very valuable information upon which to base a prognosis, is certain cases of strabismus. If we hold before such a patient two bits of colored red cardboard, one a short distance from the other, and cause the patient to fix one, the one held nearest the periphery will appear much the brighter, showing there is a partial loss of central acuity of vision. A careful examination of such a case may cause us to give a very guarded prognosis as to favorable results from any operative procedure. Schweiger, I believe, first pointed out this symptom. Recently I had such a case in which one eye was emmetropic, while the other had H. of 5.00 D. with partial central scotoma, strabismus, which had been previously operated on, and a vision of only fingers at ten feet, which glasses improved very little. The ophthalmoscope showed nothing abnormal in the macular region so far as I could detect.

Concentric contraction of the visual field and modification of the color field we shall consider together, as we nearly always have disturbance of the color field in contraction, although we may have very profound color disturbance without peripheral restriction. Whenever we have a field with very pronounced concentric limitations, together with profound color alterations, we may know we have a very serious condition of things to deal with. Under all circumstances they indicate great destruction of, or interference with, the function of the nerve element.

Among local diseases of the eye wherein there are concentric restrictions of the field, glaucoma is, perhaps, the most important. Here there is contraction on the nasal side more or less marked. The field taken at intervals in the progress of a case of glaucoma, detached retina, etc., will give us valuable information of the progress of the case, whether improving or growing worse.

We may lay it down as a general rule that all diseases of the brain and spinal cord which produce eye symptoms, first manifest themselves by modifications in the form and functions of the visual field. In brain diseases the perimeter, in conjunction with the ophthalmoscope, gives us very valuable information, and often will make clear very obscure cases.

Cases of optic neuritis, with great swelling of the disc, often give us rapid changes in the outlines of the field, with concentric restriction of

the color field, and, by means of this, we can follow the progress of the case and determine when it is safe to omit treatment. Such cases, with complete obliteration of the red and green fields, for a short time, may not be entirely hopeless, as they will sometimes very rapidly improve if the pressure upon the nerve fibres can be removed before their integrity is destroyed.

Atrophic changes of the optic nerves, from whatever cause, produce very profound disturbances both of the objective and color fields. In this condition there is more or less increase of the connective tissue of the nerve fibrillae, which, pressing upon these, destroys their function. This may be the result of inflammatory conditions anywhere along the course of the nerves, of tumors pressing upon the nerve, of diseases of the spinal cord, etc., etc.

Change of a marked character in the color field is a constant symptom of atrophy. The colors are affected in the following order mostly: First, green; then red, blue, etc. The perception for the first two may be greatly modified, while the field for blue may be nearly normal, showing the utility of taking the field for various colors.

A pronounced concentric restriction of the visual and color fields is a very frequent symptom of locomotor ataxia, whenever any eye disturbance is present, and is often one of the first symptoms in this serious trouble. In multiple sclerosis we often have sector-like deficiencies in both the objective and color fields, and we may have the same condition present in certain atrophic changes from other causes, and this modification of the field is one of very grave import, almost certainly indicating a progressive destructive disease of the nerve tissue.

Case I. C. W., aged 30; farmer; always healthy. O. D., V.= $\frac{1}{2}$. O. S., V.= $\frac{1}{2}$. Four years ago began to have severe headache, accompanied with sleeplessness, which has recurred at intervals ever since, and seems to have gradually grown worse. Has also complained at times of pains or numbness in legs, but his most prominent symptom has been the sleeplessness. Upon examination I find his refraction is normal and vision good. The ophthalmoscope shows slight choroidal changes near the optic papilla, with paleness of the nerve toward the temporal side in either eye; nerve somewhat contracted, giving a beveled-off appearance to the borders of the discs; in other words, a slight indication of beginning atrophy. The field of vision is very greatly restricted for red in either eye. A further general examination gave partial loss of patella reflex, a staggering gait when attempting to walk

with eyes closed, and a tendency to fall when standing with feet together and eyes shut.

Case II. T. K., aged 52; clerk; general health always good; has been an inveterate smoker. O. D., V.= $\frac{8}{24}$ (?). O. S., V.= $\frac{8}{24}$ (?).

In August, 1885, vision began to fail very rapidly, and has failed gradually ever since until he can not read even very large print. Has never had any pain in eyes or head, or other general symptoms. The ophthalmoscope shows both discs of a pale, bluish, pearly tint, contracted in size, and arteries of diminished calibre. The field shows some concentric restriction for white, blue, and red, while the green field is very greatly and irregularly altered, as you see.

In this case there is absolutely nothing discoverable to account for this grave lesion but the habitual excessive use of tobacco. The marked change in the green field is a very unfavorable symptom.

Case III. F. O., German, aged 40; merchant. First saw him October 2, 1885. Then had had "rheumatism" for past three months; thin, emaciated, and generally broken down; also had syphilis, tertiary symptoms being present. Has always used tobacco excessively, both chewing and smoking; has had difficulty with vision for past year or more, and at present is unable to read very large print, and glasses do not improve this. The ophthalmoscope shows both optic discs small, round, depressed, pale, pearly luster, atrophic; arteries slightly diminished in size. The field shows not only a good deal of concentric restriction, but very great and irregular modification of the red and green fields, as indicated on this diagram. Besides this the patient at first stated that he could see letters and small objects better by looking off to one side, showing a partial central scotoma; but this symptom afterward subsided. His vision at this time was O. D. $\frac{8}{60}$, O. S. $\frac{8}{60}$.

Under iodide of potassium in increasing doses, hydrarg. bichlor. internally, and strychnine hypodermatically into the temples, and entire omission of tobacco, his general health improved very much, but the eye symptoms remained stationary, except the partial central scotomata disappeared. The prognosis of this case is decidedly unfavorable, so far as his eye trouble is concerned.

These cases are sufficient to illustrate some of the more important modifications of the visual field, depending upon atrophic changes in the optic nerves, from a variety of causes.

You will also perceive the great advantage, if not the necessity, of taking the field of various colors, particularly of red and green, as the

perception of these latter colors may be very greatly modified without marked alterations in the field for blue or white, and these gives us very important data upon which to base our conclusions.

Another advantage perimetry gives us is the localization of certain central lesions, more or less accurately, such as hemorrhages, emboli, etc., etc., in the line of the optic tract. Thus in certain cases of apoplexy we may have one-half of the field of vision entirely cut off, either to the temporal or nasal side of the fixation point, or on the temporal side of one eye and the nasal side of the other. These cases are explained upon the theory of the decussation of the optic nerves at the chiasma, whereby a lesion of the optic tract of the right side products a left-sided hemiopia, or vice versa. So a lesion at the anterior angle of the chiasma would produce loss of function of the inner part of each retina, and consequently obliteration of the two temporal halves of the fields.

Rarely we have what is known as altitudinal hemianopsia, wherein the superior or inferior halves of the fields are obliterated. This condition denotes a probable lesion of the occipital convolutions of the brain. The present generally accepted theory is that the visual areas, as well as the color perceptive centers, are located in the occipital lobes of the brain, so that any disturbance of these centers will be indicated by a partial or total loss of vision or of color perception.

Munk has drawn this conclusion as the result of many experiments upon, chiefly, dogs and monkeys:

"On the cortex of each occipital lobe the anterior segment corresponds to the upper half of the retina; the posterior to the lower half; the external half to the temporal half of the eye of the same side, and the internal half to the nasal half of the eye of the opposite side. Even though ever so small portions of the sections of the cortex in question were removed, the corresponding part of the retina would be rendered blind."

It is not inconsistent with this theory, therefore, to say that a less marked lesion of any of these parts will produce more or less pronounced disturbance of the visual perception, which may be indicated on the field of vision.

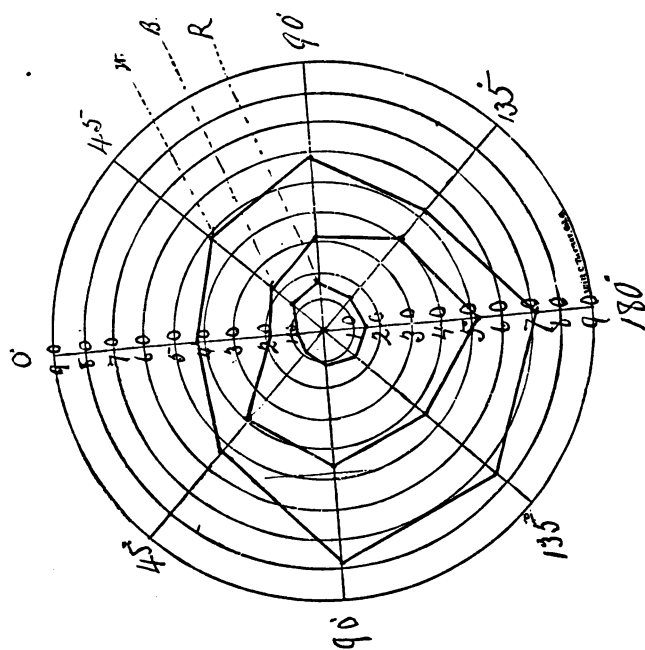
I trust I have thus, very briefly and imperfectly, made clear some of the modifications of the visual field in various pathological conditions, and the uses which may be made of perimetry in the better elucidation of many obscure diseases.

Many of these cases never see a specialist, unless accidentally, as there may be no visual disturbances perceptible to the patient in their early history, and consequently this valuable means of diagnosis is not often made use of.

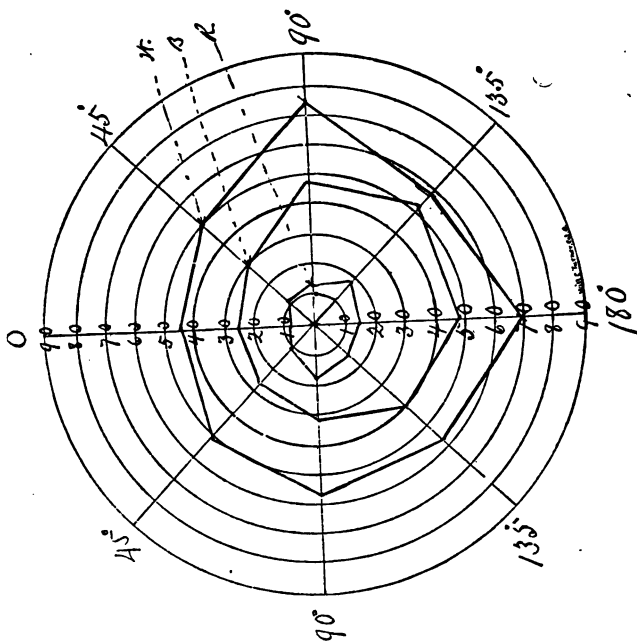
[From lack of space several cases have been omitted from this report.—EDITOR C. M. J.]

CASE I.

LEFT.



RIGHT.

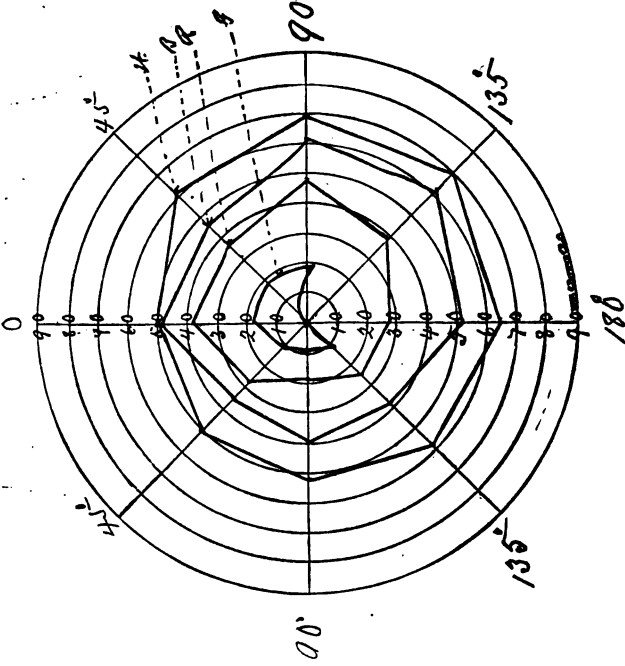
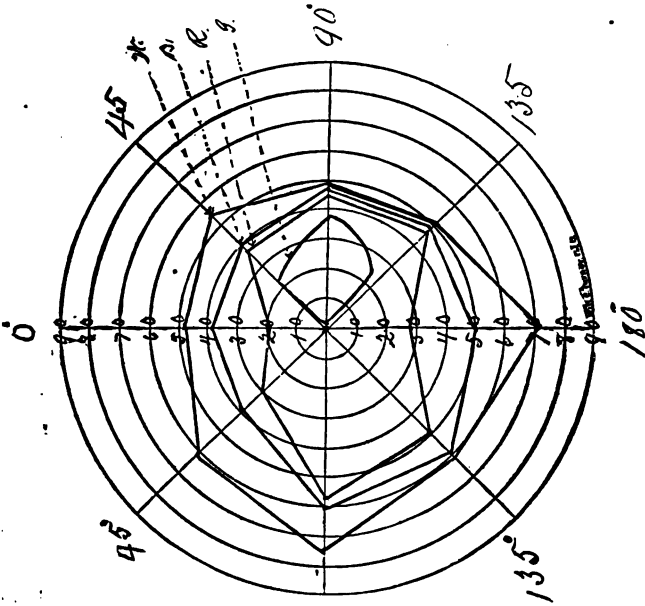


W.—White field. B.—Blue field. R.—Red field.

LEFT.

CASE II.

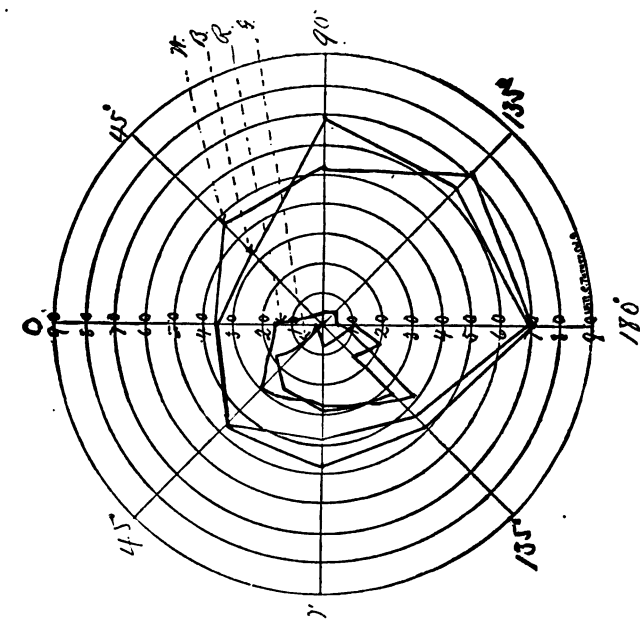
RIGHT.



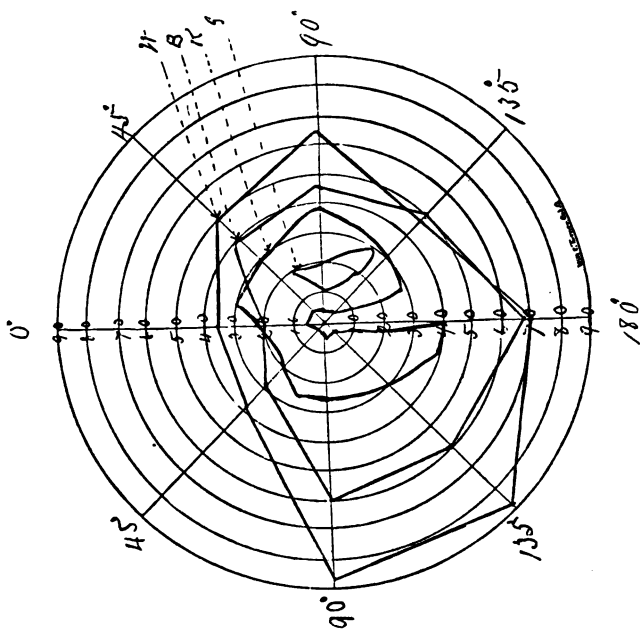
W.—White field. B.—Blue field. R.—Red field. G.—Green field.

CASE III.

RIGHT.



LEFT.



G.—Green field.

R.—Red field.

B.—Blue field.

W.—White field.

A PARTIAL STUDY OF THE STATISTICS OF THE INSANE IN OHIO, COVERING A PERIOD OF TWENTY-FIVE YEARS.

BY EDWARD J. WILSON, M. D., COLUMBUS, O.

Read before the Ohio State Medical Society, June, 1886.

The statistics that are presented in this paper have been collected from the following sources: First and chiefly, from all the insane asylum reports that have been published in this State since 1860. These reports constitute a part of the State Executive Documents, and can be found in the State Library. Second, the reports of the Board of State Charities. Third, the State Secretary's exhibits of the annual returns of lunacy inquests made by the probate judges in the various counties of the State. The reports of the United States Census Commissioners of '60, '70 and '80 have also been consulted.

The collection of these statistics was undertaken with a view to learning whether there has been an increase in the number of occurring cases of lunacy which could not be due to the increase which has taken place in the population.

It will not be necessary to adduce any evidence to establish the fact that a large increment has been added to the insane population of the State in the time covered by this review. The growth in number and capacity of the institutions for the cure and treatment of this unfortunate class must be apparent to a casual observer. The aggregate accommodating capacity of the State asylums now is nearly one hundred and fifty per cent. greater than it was twenty-five years ago, while the insane population of the infirmaries was fifty per cent less at that time than it is to-day. But while this growth has taken place in the insane population, there has been a large increase in the general population of the State, so that, with no increase in the proportion of the insane, there would be a large increment of this class in so long a period of time. In 1860, the number of insane in the State returned by the Census Commissioners was 2,275. The population of Ohio in the same year was 2,344,000; so that the ratio of the insane to the population was one to 1,030. In 1870, the number returned by the census commission was 3,414, which would, to a State population of 2,666,000, show a ratio of one to 780. In 1880, the number of insane returned was 7,286; the population of the State, according to the same report, was 3,198,000; so that the ratio of the insane to the people was about one to 450.

On the 21st day of November, 1885, the whole number of insane in asylums was 4,236; in jails, 612; in infirmaries, 1,398; so that the total number of insane in all public institutions was 6,246.

If to this number there be added the same percentage of cases as were found outside the asylums, jails and infirmaries in 1880, the whole number in the State, November 21st, 1885, would be 8,619. The voting population, in November, 1884, was 780,000 and would represent a population approximating 3,540,000; the ratio of the insane to the people was about one to 400.

Thus it would appear that while the population of the State is now fifty per cent. greater than it was in 1860, the insane population is two hundred and eighty per cent. greater than it was at that time. It should be observed, however, that this growth relates only to the population of the insane, and does not necessarily imply that an increase has taken place in the number of occurring cases of lunacy. It will readily be seen that if the rate of mortality is less now than it was twenty-five years ago, the population of the insane might increase although the ratio of occurring cases be stationary. These estimates, too, are taken from the census reports, and the more accurate means employed, in recent years, for returning the number of the defective class may account, in part, for this truly alarming growth in the number of the insane.

In order that we may learn whether there has been an actual increase in the tendency to insanity, only the new, or first, cases occurring in a given period of time, should be taken as the basis for calculation. Let the question be studied in this way and, for convenience, let the time over which this review extends be divided into quinquennial periods. Carefully excluding all readmissions, and counting only the first cases of both sexes received into all the state asylums since 1860, the facts obtained are shown in the following table :

						Per cent. of increase.
November 21st, 1860, to November, 21st, 1865, Received	2,251.					
" " 1865, " " " 1870, "	2,465.	9.4.				
" " 1870, " " " 1875, "	3,070.	24.6.				
" " 1875, " " " 1880, "	3,783.	23.2.				
" " 1880, " " " 1885, "	4,701.	24.2.				

So it is seen that while the State population has been multiplying less than fifty per cent., the number of first admissions has multiplied 208.8 per cent. It should be remembered that this represents the increase that has taken place in the occurring cases of lunacy, and is not an estimate of the

growth in the insane population, which might have been more or less rapid than the increase in admissions according as the rates of recovery and mortality were greater or less during the periods named.

It is apparent that there has been a large increase in the number of occurring cases of mental alienation, and that during the last fifteen years the rate of growth has been one of almost continued proportion. Making due allowance for the growth in population, it would seem that where one person was admitted into the hospital during the first period, there were three admitted during the last period ; if this be true, all other things being equal, it would follow that the liability to insanity is now three times greater than it was then.

It may be thought that the better accommodation now provided in the asylums causes a large proportion of the insane to seek admission ; but but this is not true. In 1860, the insane population of the asylums numbered 1,258, which was fifty-five per cent. of the reported population. In 1870, the number of insane in the asylums was 2,135, which was sixty-two per cent. of the total insane population. In 1880 the asylum population was 3,500, and was forty-eight per cent. of the entire number in the State. In 1885 there were 4,390 patients in the asylum, which was about fifty-one per cent. of the whole number in the State. It is thus seen that the proportion of the insane now treated in the hospitals is less than it was in 1860 and 1870. This is probably due to the more generally recognized fact, among physicians, that many of the cases heretofore sent to the hospital for treatment can safely, and with as good results, be treated at home.

The death rate, calculated upon the mean number of patients under treatment for the various periods, is as follows :

Period.	Mean No. Resident.	No. Deaths.	Per Cent.
First	1,399	100	7.14
Second	2,902	244	8.4
Third	5,178	505	9.77
Fourth	11,657	658	6.58
Fifth	13,412	1031	7.68

The death rate, during the first decade, was 7.9 per cent. and during the last, 7.17, per cent. and for the twenty-five years, it was 7.06 per cent. This is a favorable showing as compared with the statistics of English hospitals. Bucknill and Tuke state (page 131, *Psychological Med.*, Ed. 1879) : "From the Lunacy Report of 1877, we learn the annual rate of mortality during eighteen years ending December 21st, 1876. The deaths (calculated on the mean number resident, viz., 33,442) amounted to 10.3

per cent." This report comprised all the hospitals in England and Wales. According to this report the percentage of recoveries during the same time was 34.1 per cent.

In the *American Journal of Insanity*, for October, 1885, Dr. Pliny Earle gives the results respecting recovery in fifteen American hospitals during a time varying from two to six years; the period ending, in most cases, in 1883. The recoveries, calculated on the admissions, amounted to 25.96 per cent. The recoveries in the hospitals of this State, during the ten years ending November 21st, 1869, were 56.02 per cent. of the admissions. During the decade ending November 21st, 1884, they were but 35.31 per cent. of the number admitted. This large reduction of nearly thirty-six per cent. in the number of recoveries, compared with the first decade, is difficult of explanation. It may be urged that it is due to the greater care now observed in the selection of the recovered class. But opposed to this explanation is the fact that notwithstanding such care the proportion of relapsing cases, computed on the recoveries, has increased, although the recovered class from which the relapses must be obtained has grown smaller.

During the five years ending November, 1869, the readmissions amounted to fifty-one per cent. of the number discharged cured. During the succeeding five years, there were readmitted 54.5 per cent. of the number discharged cured. During the period ending November, 1879, the percentage of readmissions increased to fifty-seven. During the last five years, of the number discharged cured 62.9 per cent. were readmitted.

Of the whole number of patients admitted from 1870 to 1875, forty-nine per cent. presented some form of mania; twenty-two per cent. were admitted with melancholia. From 1875 to 1880, fifty-one per cent. of the admissions were of some form of mania; thirty-four per cent. had a variety of melancholia. From 1880 to 1885, fifty-one per cent. were admitted under the head of mania, and thirty-nine per cent. under melancholia.

The question naturally arises, in considering the causes of the increase in the liability to insanity which seems to have taken place, have mental diseases undergone any change in type or quality in the time covered by this review? The question is suggested by the increase that has taken place in the proportion of patients admitted with melancholia, by the large reduction in the percentage of recoveries, and corresponding increase in the stationary or incurable class.

In the twenty-five years there were received in all 20,564 patients, of whom 10,380 were males, 10,184 females. 3,467 males and 4,004 females were married; the latter exceeding the former sixteen per cent. The number of unmarried males was 3,185, and the number of unmarried females 2,408; the males outnumbering the females thirty-three per cent. Of the 10,380 males, 4,324, or 41.5 per cent., were farmers. According to the census of 1880, farmers constituted fifty-two per cent. of the total male population of the State. 2,567, or 24.7 per cent. were artisans, and 2,063, or about twenty per cent., were laborers. Thus it is seen that of the total male population of the asylums, eighty-six per cent. were contributed by the working classes. 309 or three per cent., were merchants. Of the professions, physicians constituted the largest number, 113, or a little more than one per cent., and the clergy constituted the least, about .5 per cent.

In 2,134 patients admitted between 1860 and 1870, heredity was given as a cause in 524 cases, or about 27 per cent. In 4,263 patients admitted between 1875 and November 21st, 1884, heredity was assigned as a cause in 1,607, or a little less than thirty-eight per cent. This would indicate that the neuropathic tendency is becoming more disseminated, and may not this be one of the causes of the smaller proportion of recoveries and of the larger proportion of relapses that obtain of late?

Intemperance was named as a cause in 1,396 male admissions, or about seventeen per cent. In these cases, however, intemperance operated as the exciting cause; nothing is said respecting it as a contributing agent, by pauperizing families and thus subjecting them to mal-nutrition and exposure, both prolific causes of insanity, as is attested by the eighty six per cent. drawn from the working people. The following summary is presented in conclusion:

The population of Ohio is fifty per cent. greater than it was in 1860.

The insane population is 280 per cent greater than it was at that time.

Since 1865, the population having increased less than fifty per cent., the admissions to the asylums have increased 208 per cent.

The ratio of the insane to the population, in 1860, was one to 1,030.

On November 21st, 1885, it was one to 400.

Fifty per cent. of the insane are cared for in the asylums; twenty-seven per cent. at home, or in private hospitals. Sixteen per cent. are in the infirmaries, and seven per cent. are confined in jails.

Of the total number admitted during the decade ending with 1870, fifty-six per cent. were discharged recovered, and during the decade ending November 21st, 1884, thirty-five per cent. were discharged cured. Percentage of recovery for the twenty-five years was 39.6.

The death rate of the insane during the decade ending November 21st, 1869, calculated on the average number treated, was 7.8, and during the ten years ending November 21st, 1884, was 7.17.

Of the whole number discharged cured during the five years ending November 21st, 1869, fifty-one per cent relapsed. During the five years ending November 21st, 1884, 72.9 per cent. relapsed.

Of 2,134 patients admitted between 1860 and 1870, twenty-nine per cent. had hereditary tendencies to insanity. Heredity obtained in thirty-eight per cent. of 4,263 cases admitted during the five years ending November 21st, 1884.

Intemperance was given as a cause in seventeen per cent. of 731 admissions. Whole number admitted in twenty-five years, 20,564: males, 10,380; females, 10,184.

From 1860 to 1865, the number of females admitted exceeded the males. The minimum proportion of males was received during the five years ending with 1865. The maximum proportion during the five years ending with 1875. It will be observed that the former period corresponded with that of the war; the latter with the period of the great financial panic.

Of the total number of males, 41.5 per cent. were farmers, 24.7 per cent. were artisans, and twenty per cent. were laborers. In all, eighty-six per cent. were of the classes whose occupation is that of manual labor.

Three per cent. were merchants.

Of the professions, physicians constituted the largest proportion, teachers next largest, and the clergy the least.

ABOUT SMOKING.—Dr. William A. Hammond, says: "If children smoke cigars, they destroy their nervous system before they are fully formed, and render themselves liable to neuralgia and various functional diseases of the brain which are certainly calculated to destroy their mental force. There is also evidence to show that tobacco in young persons actually interferes with the development of the body in regard to size—that it stunts the physical system. It certainly impairs digestion, for they can not use tobacco without spitting inordinately. The saliva expelled

from their bodies is one of the most important of the digestive fluids, and the proper digestion of the food in the stomach is materially interfered with when there is not enough saliva left to mix with their food before it is swallowed. Again it certainly impairs hearing and eye-sight. I have seen several instances of children having their eye-sight injured seriously, if not irreparable, by the use of tobacco. The excessive use of tobacco is injurious to everybody, adults as well as infants, male as well as female."

The *Medical and Surgical Reporter* commits itself to the opinion that a male is preferable to a female, as a doctor's door keeper, but concedes an exception in the case of gynecologists, whose door-keepers should always be females. It thinks it more decorous for a male to open a door than for a female to perform this important office. This is the only reason for its preference. This reason does not rise to the requirements of the occasion. Our cotemporary should furnish some reason more in keeping with the scientific bearing of this important function. Here is a rare chance for it to express itself.—*Med. Age*.

FEMALES AND WOMEN.—Mr. G. E. Williamson (Newcastle-on-Tyne) writes: How is it you have allowed the Ingleby lecturer to write in the *JOURNAL*: "On some Functional Disorders of Females?" Surely it would have been kind to tell him that "female" is not synonymous with woman or girl, and that it is only used in that sense by the illiterate and the vulgar. Seeing the title, I read the article, expecting it to be a study in comparative physiology.

Johnson says. "Female, a she, one of the sex which brings young; not male." His example is from Leviticus: "If ye offer it of the herd, whether it be male or female, he shall offer it without blemish." A different example, in which also the word is correctly used, is: "The ascetic rule of St. Basil, which the monks follow, is very severe; no female, not even a cow or a hen, is permitted to approach the Holy Hill (Mount Attios)."

I saw in one of our local newspapers, a short time since, an account of "a female found dead in a ditch." I have myself found females dead in a ditch, but never a woman. It is, however, unnecessary for me to multiply examples, as I know you will agree with me that the title of the lecture contains an excellent example of the wrong use of the word.—*Brit. Med. Journal*.

*MEDICINE AS IT WAS TAUGHT AND PRACTICED
IN 1659.*

BY R. HARVEY REED, M. D., MANSFIELD, OHIO.

The following classical quotations will be found in the "Pharmacopœia Belgica; or, the Dutch Dispensatory, Revised and Confirmed by the Colledge of Physitians at Amsterdam. Wherein is described: I. The Virtues, Qualities and Properties of Every Simple. II. The Virtues and Use of Compounds. III. Directions and Cautions in Giving the Medicines. Whereunto is added the *Complete Herbalist*, Being a Physicall Discourse of all of the Herbs and Fruits, shewing their various Virtues and Qualities, as they are frequently used in Medicines; Together with many excellent Receipts.

London, Printed by E. C. for Edw. Farmham, in Popes-head, Also by Robert Horn, at the Turk's Head, in Cornhill, 1659."

"*A Plaster of Frogs With and Without Quicksilver.* Take Oyle of Chamomel, Dill, Lillies, Spike, of each 4 ounces, of Saffran 2 ounces, Hogg's Suett 2 pounds, Naturall Oyle of Bays 8 ounces, Male Frankincense 2 ounces and a half, Euphorbium 10 drams, Frogs alive washt in wine 12, Earth-worms washt in Wine 7 ounces, Leaves of Featherfen, Flowers of Camels Hay, Staechas, of each two handfuls, Juice of Elder Roots, Elecampane, Clear Turpentine, of each four ounces, Storax liquid 3 ounces; Lytharge of Gold 2 pounds."

"*To Cure the Emrods.* The Piles come from too great abundance of melancholy blood gathered in the Veins of the Fundament, and sometimes they appear and sometimes they do not, sometimes they bleed much, which is good if it last not too long, for nature seeks to help her self. As the Piles bleed too much, and do not stop of themselves, then seeth Sumac in Beer, and bathe the parts therewith before a good fire. The Leaves of an Oke and the Acorns sod in the same manner, are very good for this purpose. But when they are painfull and come not to bleed, take Linseed Oyle, the Yelk of an Egg, Fine Meal, upon some Flax; Plantan Water with Syrup of Quinces is good to drink against bleeding of the Emrods."

"Quicksilver killed with Turpentine eight ounces, Strong Wine 4 pounds, White Wax what is sufficient. Make a plaster according to art. This is good against hard swellings, but most in use for the French Pox."

"*Carrats*. Yellow and red Carrats are well known both by Poor and Rich. Yellow Carrats eaten with meat do nourish well, and warm the inward parts, cause one to make water well, and are a great help to feed poor people."

"*Fennell Seed*. *Foeniculum* in Latine, it is a well-known grey Seed that groweth abundantly in Gardens, and encreaseth wonderfully, is much used in Physic, and is singular in the gravell.

"Fennell is hot and dry in the second degree, and the Seed remains three years in its strength. Fennell Seed eaten strengthneth the Brain and the sight, cleanseth the blood and opens Womens' Courses, makes nurses to abound with milk, it strengtheneth the Stomach and hinders the wind, it openeth the Liver, Milk and Bladder, and makes one to void water well, helps to break the Stone, and is good for pain in the Lines, it drives off the cold piss of *Lues veneria*, and people find profit by it. Distilled Fennell water is very good to wash sore eyes with, and heals them."

A CONVENIENT SUGAR TEST.—A correspondent of the *Atlanta Medical and Surgical Journal* mentions a convenient substitute for Fehling's solution in testing for sugar in the urine. The ordinary solutions deteriorate on keeping and are liable to throw down the suboxide of copper themselves if they have not been freshly prepared. Prof. Holland, in his lectures at Jefferson Medical College, gives the following test fluid, which is very efficient, is easily prepared, and is not spoiled by keeping:

R. Cupric sulphate,	-	-	3j.
Glycerine,	-	-	f 3j.

To make the test add five drops of this solution to the drachm of liquor potasse, in a test tube. Boil a few moments to test the purity of the fluid; should it remain clear, then add a few drops of urine. If glucose be present in quantity, there is at once thrown down a red precipitate, just as in the ordinary Fehling's test. To detect minute amounts of sugar, not shown by above procedure, after making the test as above, add half a drachm of urine; boil and set aside. If sugar be present, even in very minnte quantity, the liquid as it cools, will turn to an olive green color and become turbid.

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“ Hick's, lens front.....	3.25	4.75
Camman's double Stethoscope.....	2.75	4.00
Graves Speculum, (convertible into Sims').....	3.50	5.50
Rectal Speculum, bivalve.....	3.25	4.50
Landis' uterine dilator.....	3.25	4.00
Landis' modified Davis' obstetric forceps.....	6.00	8.00
Hodge's obstetric forceps.....	5.75	8.00
Hale's (or Sawyer's) short forceps.....	5.25	6.50
Universal Hard Rubber Syringe, 5 pipes.....	3.00	4.50
Obstetrical bag, containing forceps, placenta forceps, perforator, blunt hook, vaginal speculum and uterine probe.....	20.00	26.75
Fahnestock's tonsilotome, finest.....	6.00	12.00
10 vial, genuine morocco pocket case.....	2.35	4.00
Amputating and minor operating case.....	19.50	27.00
“ “ trephining case.....	29.60	40.00
Hypodermic Syringe, ordinary.....	2.00	3.00
“ “ finest; glass and hard rubber.....	2.75	4.00
Aspirator, and stomach pump (a perfect instrument).....	19.00	27.00
“ French style.....	11.50	15.00
Post-mortem case.....	10.75	12.00

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versus

Dilute Phosphoric Acid.

The attention of the profession is respectfully invited to some points of difference between Horsford's Acid Phosphate and the dilute phosphoric acid of the pharmacopœia. Horsford's Acid Phosphate is a solution of the phosphates of lime, magnesia, potash, and iron in such form as to be readily assimilated by the system, and containing no pyro- or meta-phosphate of any base whatever. It is not made by compounding phosphoric acid, lime, potash, etc., in the laboratory, but is obtained in the form in which it exists in the animal system. Dilute phosphoric acid is simply phosphoric acid and water without any base. Experience has shown that while in certain cases dilute phosphoric acid interfered with digestion, Horsford's Acid Phosphate not only caused no trouble with the digestive organs, but promoted in a marked degree their healthful action. Practice has shown in a great variety of cases that it is a phosphate with an excess of phosphoric acid that will better meet the requirements of the system than either phosphoric acid or a simple phosphate. "Phosphorus," as such, is not found in the human body, but phosphoric acid in combination with lime, iron and other bases, *i. e.* the phosphates, is found in the bones, blood, brain and muscle. It is the phosphates and not the simple phosphoric acid that is found in the urine after severe mental and physical exertions, or during wasting diseases.

We have received a very large number of letters from physicians of the highest standing, in all parts of the country, relating their experience with the Acid Phosphate, and speaking of it in high terms of commendation.

Physicians who have not used Horsford's Acid Phosphate, and who wish to test it, will be furnished a sample on application, without expense, except express charges.

RUMFORD CHEMICAL WORKS,

Providence, R. I.

 BEWARE OF IMITATIONS.

MEDICINE.

SMALL DOSES.—The present tendency in prescribing is to elegance and pleasantness. Although we have capsules, wafers, sugar and chocolate coatings, yet the drug may prove inert by the insolubility of the coating. Since the discovery of various alkaloids, small doses have become more common. If drugs be effectual in small doses frequently repeated, why not prescribe small doses?

In diphtheria, scarlatina, follicular tonsillitis, potassium chlorate in one grain doses every half-hour affords much relief, and is curative.

One grain doses of croton chloral every half-hour in many forms of neuralgia are beneficial.

In obstinate urticaria, salicylate of soda, in two grain doses every half-hour, acts well; also drop doses of balsam of copaiba every half-hour.

The vomiting of drunkards is often helped by half-drop doses of Fowler's solution every half-hour. This is also good in vomiting of pregnancy.

In erysipelas, the muriate of pilocarpine, $\frac{1}{10}$ grain, hypodermically.

Wine of ipecac in drop doses every fifteen minutes will often arrest obstinate vomiting caused by cancer; also useful in children.

For vomiting of infants, A. A. Smith, of New York, has used one grain of calomel to one ounce of lime water; to this add one pint of pure water, and give a teaspoonful of the mixture every ten minutes.

In wheezing and cough of children with bronchitis, good results may be obtained with tartar emetic, one grain to two pints of water; teaspoonful every half-hour.

Sick headache is often relieved by one drop of tinct. nux vomica every five minutes.

One of our best remedies for inflammation of the bladder is tinct. cantharides, one drop every hour.

In excessive menstruation, fl. ext. ergot has been successfully used in minim doses every half-hour, for six or eight hours before the expected flow.

A simple febrile movement, with hot dry skin, full and bounding pulse, may be relieved by half drop doses of tinct. aconite root every half-hour; also useful in acute nasal catarrh.

Sub-acute nasal catarrh, with abundant secretions, is often allayed by minim doses of tinct. belladonna every half-hour, until eight or ten minims are taken.

In malarial fever, when quinine fails, picric acid, gr. $\frac{1}{4}$, in combination with ammonia, is used with benefit; also beneficial in pertussis.

In asthma, with indigestion and anemia, Fowler's solution in one drop doses, often proves remarkably beneficial.

Apomorphia, gr. $\frac{1}{10}$ three or four times a day, often produces brilliant result in spasmodic cough.

Cannabis indica, gr. $\frac{1}{4}$, given for weeks, is a useful agent in the treatment of megrim.

Atropia, in doses of $\frac{1}{10}$ of a grain, usually controls night sweats

Digitalis, in small doses frequently repeated, exerts a beneficial influence over different kinds of hemorrhages.—*Nashville Jour. Med. and Surg.*

REMOVAL OF TAPE WORM.—As the result of many years experience in Marine Hospitals, during which time he has successfully treated 2,782 cases, Dr. Berenger Ferrand declares that of all the teniacides, from calomel to turpentine, through the whole alphabetical list of vermifuges, none can compare for certainty and safety with the bark of pomegranate root, or rather its alkaloid, pelletierine. The latter is preferable, since the value of the bark depends entirely upon its contents of this principle. But pelletierine, certain though it be when used properly, fails like all the balance when the proper precautions are not rigidly adhered to. The following is an abstract of Dr. Ferrand's method of exhibiting it. Learn first whether your patient be easy or difficult of purgation. This is an important point, as will be seen subsequently, since the dose of pelletierine and of the accompanying purgative must be determined by his habit in this respect. On the evening previous to the exhibition of the remedy the patient is put upon a light diet, consisting of milk with the addition of bread or rice only. He is instructed to remain in bed in the morning, and at 6 o'clock he is given an infusion of senna. The dose in ordinary cases is from $2\frac{1}{2}$ to 4 drams of the leaves infused in 3 ounces of water, to which is added, as a corrigent, a half ounce of any syrup. At 7 o'clock he is given one half of the dose of pelletierine, which consists of two-thirds of a grain of the alkaloid dissolved in syrup of orange peel. He is now instructed to lie down upon his back, perfectly quiet, with his eyes closed. By this means griping and vomiting are generally avoided. At the end of half an hour the balance of the pelletierine is administered, with the same instructions as to remaining quiet. At 8 o'clock, providing there is no nausea, griping or vomiting,

a full dose (from 6 to 10 drams) of castor oil is given, either raw or in emulsion. If there is nausea, griping or vomiting, the oil must be delayed for another quarter or half an hour, but not longer. The oil must be administered within a half hour after the last dose of pelletierine. The patient should continue to lie in bed until all the nervous disturbances which are almost certain to follow the pelletierine have subsided. He must also be instructed to refrain from going to stool as long as possible after the first symptoms of catharsis appear. If on the contrary, the senna and oil fail to produce catharsis within a reasonable time after administration, a clyster of salts and senna (1 ounce of the leaves to 5 ounces of hot water, to which is added 10 drams of Glauber salts dissolved in 3 ounces of water) should be given. If, after commencing to pass away, the bowels should cease acting while a portion of the worm still remains in the intestines, traction must not be resorted to. A second or even a third clyster must be given. These last injections may consist of warm infusion of pomegranate root or a warm solution of Glauber salts. The vessel over which the patient sits should be half filled with warm water. Should the worm not make its appearance in the first stool, the clyster must be repeated as directed in the foregoing paragraph. The difficulties in the way of uniform success are the appearance of vomiting after taking the first dose of pelletierine, and insufficient purgation. As a general rule the best results are achieved when the purgation is rapid and active. If, after all precautions and attention to detail, the worm is not passed, the doctor recommends that at least a month be allowed to elapse before another attempt is made. If tried sooner the disappointment is almost sure to be duplicated.

TUBERCULAR AND FIBROID PHTHISIS.—The following differential diagnosis appears in the *Medical World*:

TUBERCULAR PHTHISIS.

1. Of constitutional origin.
2. Usually affects both sides.
3. Usually attacks youth.
4. Elevation of temperature.
5. Elevated circulation.
6. Loss of flesh.
7. General exhaustion.
8. No albumen in urine.
9. Edema unusual.
10. Death usually within three years.

FIBROID PHTHISIS.

1. Of local origin.
2. Usually affects one side.
3. Usually attacks middle age.
4. No elevation of temperature.
5. Normal circulation.
6. Little or no loss of flesh.
7. Little or no exhaustion.
8. Always albumen in urine.
9. Edema always present.
10. Death unusual before five years.

DIAGNOSTIC TABLE OF DISEASES OF THE SCALP.

ECZEMA.	PUSTULAR SYPHILIDE.	PSORIASIS.	RING WORM.	SEBORRHEA.
1. Mostly in children.	Mostly in adults.	Rare in children.	Nearly always in children.	
2. Often entire scalp.	Mostly in small patches.	Usually small patches, abrupt border.	Circular patches, extending at edge, dry, scaly center, papular, vesicular or pustular border.	Larger, irregular patches.
3. Severe itching.	No itching.	Itching not usually severe.	Slight itching.	Moderate itching.
4. Crusts brittle, often thick; scalp red, infiltrated, excoriated, exuding serum or pus.	Deep ulcerations, abrupt edges and unhealthy base.	Scales dry, white and silvery, seated on red, dry, slightly elevated base.	Hair broken off like a stubble field; dry and split. Parasites seen with microscope.	Hair often falls out, and may not be reproduced.
5. Patches shading off into healthy skin.	Other signs of syphilis present.	Psoriasis elsewhere, on elbows and knees.	Contagious.	Scales greasy and seated on a red, shiny, not exuding base.
6. Hair healthy, not broken or split.				

— From Rohe's Monograph on Eczema.—*Med. World.*

INGLUVIN.—A very learned name for a remedy is Ingluvin. It is the essential principle of the gizzard, and bears the same relation to poultry that pepsin does to the higher animals. The honor of its discovery and utilization, in its crude state, remotely dates with the Chinese gastronomer, as well as to the Caucasian chemist, in its refined condition. From time immemorial the inhabitants of the Celestial Empire have used the gizzard of chickens and ducks in nearly all made dishes. Their writers have recommended the practice as a sovereign treatment of dyspepsia, weak stomach and vomiting. A favorite prescription of Chinese physicians for chronic indigestion is to cut up and digest chicken gizzards in hot water until they are reduced to a pulp, and then add some spices. A tablespoonful or two of the resulting paste is taken at each meal until the patient has entirely recovered. From China the practice passed to other parts of Asia, and was adopted here and there among the Mediterranean people. Strange to say it was never learned by the great nations of Europe until the latter part of the present century. On the other hand, the organic chemists of Europe discovered, about 1850, a powerful nitrogenous radical in the gizzard. Experiments thereafter showed it to possess many of the qualities of pepsin. These experiments led to its isolation. Numberless experiments have proven it to be a very valuable addition to therapeutics. Where pepsin refuses to act, and where, in severe cases, it has even been rejected by the stomach, Ingluvin effected relief rapidly and with the greatest ease.

In four recent cases of poisoning by root beer (Brooklyn, June, 1886), Dr. George Everson, Jr., a well known physician of that city, reports that after pepsin and all similar compounds had been rejected by the stomachs of his patients, Ingluvin stayed the retching and enabled them to retain and digest food.

Dr. Lassing reports a similar experience in several cases of acute dyspepsia.

A priori, it would seem as if Ingluvin should be more efficient and potent than pepsin in many cases of physical disorder.

Our poultry are chiefly granivores and have no beak nor other buccal apparatus for crushing the hard grain and seeds on which they so largely feed. The food is swallowed when apprehended and passes directly into the crop or gizzard. This seems to act both mechanically and chemically. Its interior walls are covered by a dense, hard cutaneous membrane, surrounded by muscles of the most powerful type. Along with the food is always a small amount of sand and gravel. The organ

acts apparently by bruising and cracking, rather than, as commonly believed, by trituration. The motion of the ingluvial muscles is accompanied by a slow but continuous exudation, from the walls of the crop, of a strong organic fluid, of which Ingluvin is the chief constituent. The hull of the grain or the shell of the seed is broken by the pressure of the walls and the gravel and their interior is exposed to the chemical action of the ingluvin. By the time it reaches the stomach it is ready for the gastric juices. From this point on, digestion proceeds as with the higher animals. As the gallinaceæ have very small salivary glands, and as the fluids secreted by these resemble the secretion of the parotid rather than that of the sublingual and submaxillary glands of the human being, it would seem as if Ingluvin played a double part, exercising the functions of the ptyalin of the saliva as well as the pepsin of the stomach. Ingluvin is prepared by the far-seeing chemists, Wm. R. Warner & Co., of Philadelphia. It is made from selected gizzards, and is so carefully extracted as to be free from all foreign organic bodies. It is already known and appreciated by the medical profession. The *American Analyst* bespeaks for it the same appreciation by its readers. We extract the following.

Prof. Roberts Bartholow, M. A., M. D., LL. D., in his late work on "Materia Medica and Therapeutics," says: "INGLUVIN. This is a preparation from the gizzard of the domestic chicken—*ventriculus callosus gallinaceus*. Dose, gr. v.—ʒ j.

"Ingluvin has the remarkable property of arresting certain kinds of vomiting—notably the *vomiting of pregnancy*. It is a stomachic tonic, and relieves *indigestion*, *flatulence* and *dyspepsia*.

"The author's experience is confirmatory of the statements which have been put forth regarding the exceptional power of this agent to arrest the vomiting of pregnancy. It can be administered in inflammatory conditions of the mucous membrane, as it has no irritant effect. Under ordinary circumstances, and when the object of its administration is to promote the digestive function, it should be administered after meals. When the object is to arrest the vomiting of pregnancy, it should be given before meals."—*From the American Analyst*, August 1st, 1886.

THE LIMITATION OF THERAPEUTICS IN INFANTILE PARALYSIS.—(V. P. Gibney in *N. Y. Med. Jour.*, *Arch of Ped.*) I. What can be done for the relief of the paralysis? Galvanism, faradism, massage, iodide of

potassium in moderately large doses, and counter-irritation to the spine are usually employed. Yet little reliance can be placed upon these agents to restore muscles when their nerve centers in the cord are dead. II. What can be done to prevent the sublaxations and deformities which arise from muscular and tendinous shortening? (1.) Avoid any undue stretching of the fibrous structures of the joint? (2.) Do not permit long maintained positions of the parts by which the muscles whose function has not been destroyed can become shortened. (3.) Apply corrective apparatus when it is necessary to oppose contraction, however slight. (4.) It is better not to leave these observations to the family. III. How shall deformities resulting from muscular and tendinous shortening be corrected? Two methods are in vogue: (1.) Traction. (2.) Tenotomy or myotomy. Traction has been demonstrated to be sufficient to overcome any and all such shortening, whether of the nature of contraction or contracture. Division of the adductors of the thigh or of the hamstrings, however, accomplishes more in a few minutes than one can accomplish by ordinary traction in as many months. IV. What remedies have we for elongated tendons and muscles? (1.) Apparatus so constructed that the parts at fault may be retained in a state of great relaxation, in the hope that inherent shortening will thereby take place. This, in the doctor's opinion, is a delusion, as apparatus is never continuously worn, be the physician ever so careful and positive in his instructions. (2.) Tendons are shortened by removal of a portion and by uniting the proximal and distal extremities. Even these operations were not attended with success until Mr. Alfred Willett resorted to a suturing of the tendon ends with the surrounding tissues. V. Synostosis as a substitute for apparatus. By obtaining bony ankylosis in the lower extremities, an increased use of the legs is obtained. Surgery, after all, offers the only relief in infantile paralysis.

TREATMENT OF ACUTE RHEUMATISM BY PROF. DA COSTA. We may begin with the assertion that no remedy has a specific action in this disease, but there are means which we may employ that will greatly lessen the after dangers. There are laid down two principal plans of treatment:

1. Salicylic Acid and the Salicylates. These are unquestionably the most speedy remedies, but should not be employed in those cases in which much weakness exists, for it greatly increases the sweats and depressions, or in those cases where tendency to cardiac complication is manifested. In these latter it has been stated to be worse than useless.

If the acid be used, which is preferable to its salts, give not less than sixty to ninety grains in twenty-four hours. Ten grains may be given in emulsion every hour, for six hours, if borne well, and then the same doses may be given at intervals of two hours.

If the salicylates are used, give three drachms in twenty-four hours. If this plan acts at all, it will do so promptly; and if good results are not achieved by the second or third day, it had better be abandoned.

2. The Alkaline plan. This consists in rapid saturation with alkalis. It lessens the tendency to heart complication, but no good can be achieved by small doses; an ounce to an ounce and a half of either the bicarbonate or acetate of potassium must be given the first twenty-four hours, half as much the following day, and three or drachms each day thereafter. Employ until the urine becomes neutral or alkaline, and then diminish the dose as above stated.

The bromides, which were formerly used, are not so rapid as the salicylates or so useful as the alkalis, but for lighter forms of the disease, with restlessness, they can be employed with good results. They also have some virtue against cardiac complications. In weak, exhausted cases, where the weakness occurs in repeated attacks, use the tincture of chloride of iron. This remedy is preeminently useful if the case be the least pyemic, or of gonorrheal origin. In treating this disease no matter what plan be adopted, it is always of advantage to add to the other treatment ten or twelve grains of quinine per day. The treatment by blisters near the joint is effective, but very painful. If a case be seen in which the joint remains involved, blister. It will always do good locally, and also have some good general influence.

As to local treatment, there is not much to say. We may wrap the joint in lint steeped in solution of potassii nitras, with a little tintura opii added, and cover with oiled silk. Some patients employ, and get better relief from, dry applications; enveloping the joint with cotton to which some powdered opium has been added.

Complications.—1. Carditis. Push the alkaline treatment to the utmost, supplementing by a certain amounts of the bromides. We must give opium to relieve pain and procure rest and quiet. Digitalis is a valuable remedy, more so in endocarditis than in pericarditis. If seen early use leeches locally. The Germans use ice over the heart, but this, to do any good, must be employed early. In most cases, at the time when seen, relief can best be had by poultices, but a blister may do good.

2. For Cerebral Symptoms, if with high temperature, besides the general rheumatic treatment, use quinine to reduce the temperature. More certain is antipyrin : give gr. vii-x every hour until impression is made, but it is not advisable to go beyond gr. xxx. We can also use application of cold cloths to the abdomen, chest and limbs. Cerebral cases without high temperature do best on stimulus in large amounts, eight ounces in twenty-four hours.—*Col. and Clin. Record.*

SALICYLATE OF LITHIUM IN RHEUMATISM. M. Vulpian has read, before the Academie de Medecine, a summary of the results of his experiments on salicylate of lithium in articular rheumatism. He states that his experiments indicate that lithium salts are not so poisonous as they are supposed to be. Salicylate of lithium is not more dangerous than salicylate of sodium, and can be administered in almost equally strong doses. In acute articular rheumatism, salicylate of lithium relieves the pain which often remains in the joint after the swelling has disappeared, whereas colchicum and salicylate of sodium have no effect. M. Vulpian believes that salicylate of lithium is especially beneficial in fibrous rheumatism. In progressive sub-acute rheumatism, M. Vulpian has seen salicylate of lithium produce great improvement. Salicylate of sodium has been successful in such cases, and produced amelioration of the patient's condition ; but both greater and more lasting benefits is obtained by salicylate of lithium. In chronic articular rheumatism M. Vulpian has found salicylate of sodium useless, whereas salicylate of lithium has had a marked effect on the joints, which become less swollen than before the treatment. In order to obtain evident results, four grammes, sometimes four and a-half or five grammes, must be given daily. Larger doses are followed by toxic symptoms. This drug sometimes induces headache and deafness, but is never followed by the distressing noises which characterize treatment by salicylate of sodium. The headache and deafness disappear quickly.—*London Med. Record.*

Dr. Jacobi said that the tendency of cow's milk to coagulate in a very hard curd could be overcome by a method which he had some years ago learned from Dr. Loomis. It consisted in adding half a teaspoonful of dilute muriatic acid to a pint of water, mix this with a quart of milk, and then boiling. The taste was pleasant, and coagulation would take effect in fine particles, as in woman's milk. — *Therapeutic Gazette.*

SURGERY.

THE GENERAL MANAGEMENT OF CASES OF ENLARGED PROSTATE. Dr. F. W. Rockwell thus concludes a paper entitled "The Pathology and Treatment of Enlarged Prostate" (N. Y. Med. Jour.):

"Three drugs are at the present time given with the belief that they exert a direct influence on the disease. I name them in the order of their value, so far as I have personally been able to judge of their effects, or ascertain the estimation in which they are held by the profession. They are ergot, iodide of potassium, and chloride of ammonium. Of the first of these I can speak in terms of confidence, since I have seen as decided effects from its use as we ever do from therapeutic agents, and in cases where no other treatment was applied. I can see why, on general principles, it should act on the muscular tissues of both bladder and gland, and I give it accordingly, in full doses.

One of my patients, who had an immense posterior and lateral hypertrophy, and who was relieved of his first retention by the smallest catheter I own, after taking pounds of the drug for a year or two, was completely relieved of his symptoms, and that with no instrumental treatment, except that necessary to empty his bladder in a few attacks of retention. Improvement of a marked character was manifest during the first three months of treatment, and I have seen the same benefit in other cases, even where cystitis of a severe grade complicated the original disease. This drug I accordingly give in most of my cases, watching my patient's general health, instructing him in the daily use of the catheter, where chronic retention exists, and also in irrigating the bladder if cystitis exists or is threatened; warning him to report any unusual appearances in his urine, watching its reaction and specific gravity, from time to time, for any indications as to treatment; impressing on him the danger of being placed in circumstances where he can not empty his bladder at will; also that he shun cold and damp, and protect his skin by suitable flannels worn next it the year through; that he be temperate in diet and drink, and especially as to quantity and quality of the latter, even with water, tea, or coffee, making his daily consumption proportionate to his experience as to his actual need, and warning him that an excess of fluid in his bladder will not be tolerated as in youth; and, lastly, I endeavor to have him acquire regular habits as to the time of passing water, especially if he has to irrigate or artificially empty the organ. Strict observ-

ance of these rules makes the life of sufferers from even advanced prostatic disease tolerable, in many cases comfortable."

INCISION, DIGITAL EXPLORATION AND DRAINAGE OF LUMBAR ABSCESES. (Edmund Andrews, M. D., Prof. Clinical Surgery in Chicago Medical College.) Lumbar abscesses are not intrinsically more dangerous than others. They are only rendered especially perilous by incompleteness of our explorations and consequent inefficiency of local treatment. The first step toward safety is in the exploration. We are confronted here by the published opinions of some of our ablest men, especially of the older class, that the opening or even the aspiration of lumbar abscesses is exceedingly dangerous.

The cases related in this paper and the established facts of antiseptic surgery prove that where a lumbar abscess can be freely opened and kept thoroughly disinfected, there is positively no danger in the proceeding. Assuming that in a given case the open method with regular disinfection is necessary, the thorough exploration of the interior of the abscess is a prime necessity, and it can not be accomplished without the aid of the surgeon's finger. The time selected should be the earliest at which a diagnosis can be made, while the abscess is a simple sac without any complicated pouches. In opening an abscess of this nature, that points in the lumbar region, the first step is to open the external sac widely and explore its floor with finger or probe for the smallest opening leading to the interior of the sac which is uniformly present and usually situated at the outer border of the mass of the erector spinæ muscle or in the angle where the crest of ilium approaches the spine. The finger should examine the interior of the cavity through this opening, enlarged if necessary, the spinal column examined to search for necrosed portions, or for the excavations when the sequestra have previously exfoliated. The limits of the sac, if too large to be explored fully with the finger, should be determined by a long bent probe or flexible bougie. When the abscess opens above Poupart's ligament, it presses away the peritoneum so that there is usually no danger in opening it in front of the anterior superior spine of the ilium, and a little above the ligament a free incision must be made to admit the finger. If it burrows upward it should be traced with a flexible metallic sound suitably bent. If the channel is traced into the lumbar region, the patient should be turned on his face and the sound cut down upon, much as an incision is made for lumbar colotomy, only keeping more toward the spine and passing into the cavity

through the groove, along the external border of the common mass of erector muscles. Drain tubes should be inserted in all openings. The upper tube will then take away the pus at its source and prevent its flowing down to the lower cavities, and the latter can be healed without difficulty, thus reducing the dangerous size and complexity of the cavern, and giving us a comparatively simple and small abscess to deal with.

The author reports five cases thus treated. One was a complicated one, and the patient died of septicemia. The other four are reported as "doing well," but none had entirely recovered at the time of making the report.

The author, after stating the conflicting views as to the method of treating these abscesses, held by different authorities on surgery, concludes as follows as the result of his experience :

1. Some lumbar abscesses recover simply by a series of aspirations, with or without antiseptic washing out. This method is simple, and, when choice presents itself, should be tested first.

2. If the aspiration plan fails, or is inapplicable, in consequence of the abscess being already open, then free incision, exploration, and complete disinfection should be carried out at once.

2. If residual abscesses appear in the course of the treatment, they should be served in the same way as the primary one.

4. The sudden evacuation of a large cavity filled with pus, provided the sac is immediately disinfected, and kept so, has none of the dangers supposed by the old authors to beset the case.—*Weekly Med. Review*.

PERITONEAL SURGERY.—(Lawson Tait in Brit. Med. Jour.) I have exhaustively studied the history of this operation, since its first successful performance by Robert Houston in 1701. Its history may be divided, roughly speaking, into three phases. The first begins with Ephraim McDowel, and ends with Nathan Smith about the year 1824; and, during these years, the whole achievements of modern surgery were almost equalled in success, if not in extent. The principle of the intraperitoneal treatment of the pedicle with the short ligature was fully established; and the great regret, in the history of the operation, is that it ever was departed from. The second phase begins with Charles Clay, who first performed ovariectomy in England on September 27th, 1842; and, during the succeeding twenty-five years, he performed 390 ovariectomies, with a mortality of very nearly 25 per cent. This second phase ends with the close of the career of Mr. Baker Brown, in 1867. Dr.

Charles Clay, unfortunately, departed from the principles of Nathan Smith, and used long ligatures. Baker Brown, on the other hand, adopted a complete intraperitoneal method; and between May, 1865, and September, 1867, he performed 40 consecutive operations upon this principle, with a mortality of only 10 per cent. The third phase in the history of ovariectomy begins with Mr. Spencer Wells, who, between 1857 and 1878, performed 1,000 ovariectomies, with a mortality of 25 per cent.; he having, most unfortunately, like his predecessor, Dr. Clay, departed from the successful method of Nathan Smith. This third phase ends with Dr. Thomas Keith, who again re-established Nathan Smith's principle; and from that, I venture to say, no one will ever again have the hardihood to make a deviation.

FINGER INJURIES. (J. T. Woods, M. D., Toledo, Ohio, in Trans. of Ohio State Medical Society):

The every-day usefulness of the fingers, and the frequency of their injury, attaches interest to an apparently trifling surgical procedure. The general character of desired results are of course well understood, and their recital correspondingly tedious, but possibly some features in detail of management may repay casual attention to the matter of

Dressings.—The treatment of all forms of wounds is, at this time, a subject of discussion, the advocates of Listerism being somewhat numerous and enthusiastic. It is still, however, a matter of doubt whether we have reached that surgical millenium when we can hope for universal repair without pus formation. None will question that this is "a consummation devoutly to be wished," but in the interval of complete and generally accepted demonstration, I have to offer certain suggestions as to the method of dressing without special reference to the antiseptic theory.

The two points to be considered are the avoidance of pain and the securing of prompt repair, and the painstaking surgeon with all his ability strives to attain these ends. He recognizes the suffering from an injured finger is just the same as that from any other source, and my endeavor in this direction has led me to the adoption of the method now to be described.

It is necessary to presume that an amputation has been properly done, and that the flaps are of sufficient length to fit easily over the end of the bone without being drawn together by stitches and stretching, and that by appropriate trimming their edges adapt in an even and uniform manner.

Any other result is unworthy operative surgery. The stitches and adhesive plaster are then both ignored; in lieu of which, to hold the flaps in place, I take a narrow pledget of absorbent cotton drawn to the required length, and laying it on a solid surface, spread its surface freely with an ointment composed of vaseline one ounce, benzoic acid one drachm. This pledget may be very thin, consisting only of a layer of fibres one-fourth of an inch wide or thicker at the will of the dresser. The flaps being adjusted in the position desired, the prepared cotton pledget is lifted from its place by means of the spatula, taken in the fingers and its edges rolled backward so that the whole presenting surface may be well covered with the ointment; it is then applied exactly as adhesive plaster would be, and will be found sufficient to secure the desired end. It is to be pressed snugly over the flap and either end molded on the parts covered by them. More of these anointed pledgets are now made and applied wherever they will aid in bringing and holding parts in desired place and the whole smoothed by gently pressing the fingers over them, care being taken that at no point shall the cotton fibre touch the sensitive surface without the intervention of the ointment. The whole cut surface is not supposed to be covered by these pledgets, and to do this a thin sheet of the cotton sufficient in size is then covered with the ointment and laid over the whole. This is smoothed carefully down and the air will of necessity be excluded while the flaps are held in place by appliances so soft and flexible that the parts are wholly painless.

Over this cotton and ointment dressing a cloth covering is to be applied, and to avoid the excess of material as well as the utter impossibility of applying smoothly a bandage over the end of a finger, I take a piece of cheese cloth, about three or four inches square, and in two opposite sides cut three tails, the middle tail being in the center, and about three-fourths of an inch in width. These narrow tails are thus opposite each other, the space between their inner ends being about one-half an inch. The narrow tails are now laid over the end of the stump, the center or uncut portion on the end, while the extremities are drawn smoothly down before and behind and held in place while the broad tail of one side is brought down and wrapped around the finger, the ends overlapping each other and covering the narrow tails previously adjusted. This done, the remaining broad tail is brought down on the other side and wrapped around the whole, care being taken that the edges near the end be smooth and without projecting edges. Thus the whole is covered and ready for the bandage which is to encircle the stump, but

not over the stump. This bandage should never be more than one-half or three-fourths of an inch in width, of thin material, and firmly rolled. The bandaging may be begun at any point, but preferably near the base of the finger, being laid across it in an oblique direction, and the short tail wrapped toward the end for a couple of turns, when the roll is used to effect a covering of a single layer over the other dressing. Stopping the bandaging at this point, a thin piece of pasteboard, or anything of sufficient flexibility and firmness to serve the purpose, and about one-half inch wide, is bent into the form of a capital letter U and just wide enough at the curve to embrace the dressed finger. This is placed over the end, the legs extending down the anterior and posterior aspects of the finger. The base of this U lies close to but does not touch the end of the finger. It may be made wide enough in curve so that it produces no pressure, or in a given case sufficiently narrow to give the flaps much support. This may be taken advantage of to apply a degree of pressure at any point by placing the appliance in other positions around the stump, and thus aid secured in molding into perfect form. The bandage is now to be continued over the whole sufficiently to hold it snugly in place, care being taken to use as little bandage as possible, and that of thin material.

It will be observed that no directions have been given to carry the bandage over any part of the hand or wrist to prevent slipping, as otherwise the dressing would do, especially when the patient tries to use the hand, as sooner or later he is sure to do. For this direction of the books, I substitute the use of thread, thus simply improving on the method of our mothers. Cutting off a liberal supply of spool thread, or other equivalent, and the patient holding his finger towards me, the middle of the thread is laid across the finger over the point where the bandage ends, so as first to secure it; a tail is thus hanging down on either side. The one on the right is seized by the right hand, the opposite by the left, between thumb and forefinger; the right hand with its thread is carried across and in front of the left, and that thread dropped, the left holding fast the thread first grasped. The right hand is now passed back of the left (and next the patient), seizes the thread that it had dropped and brings it back to the right side. Thus the same threads are in the same hands with which the movement began, while they are crossed below the finger. Drawing this taut as desired, both are carried up on corresponding sides of the finger and the same repeated on top, then carried below, looped, and so on over the whole dressing, locking

each time both above and below, and at last tying firmly. The consequences are that all parts are snugly held in place, the thread nowhere becomes loose, and the dressing is just as sure to retain its position as that the method is carried out with reasonable care.

Remarks.—Judging from description it is fair to conclude that this procedure is complicated, whereas the fact is that it is the most simple possible. Using the greatest practical brevity in describing, the details of any method seem verbose and confusing, but once done, the whole is so plain, so easy and satisfactory, to both patient and surgeon, that neither will be likely to substitute it by any other.

It would also seem to be bungling and excessively warm, both of which inferences are wrong. The supporting absorbent cotton pledgets should be thin, and the portion that is applied over the whole may be quite thin also. A single layer of cheese cloth is then all that is added over the end of the stump. The bandage must also be thin, and used sparingly. The U-shaped protector described not only aids in supporting where support is needed, but may be used as an aid in molding the end into desired shape. The patient will not allow you to omit it after he has once had it applied, as it almost perfectly protects the tender surface from the little taps and blows it would otherwise receive, and thus saves him from the most vexatious kind of pain, while the method of using the thread as described is simply perfection.

Finally, this whole dressing is readily removed by cutting all the threads across and unrolling the bandages as they were applied and quietly raising the cotton from its place without soaking. It may be best sometimes to run the scissors under its lower edge and cut it through for some distance towards the end, but trifling care will enable the dresser to remove it without discomfort to the patient. The most tender finger stump may thus be dressed, undressed and redressed at will without the infliction of the most trifling pain. If these are ends to be desired, then is this detail worthy of attention and practical adoption.

A QUARTER OF A CENTURY'S SURGERY: ITS LESSONS, ITS FAILURES, ITS DISAPPOINTMENTS, ITS PROPHECIES. (From an address delivered before the Sheffield Medico-Chirurgical Society by Dr. A. Jackson.) "Surgery," said Mr. Erichsen at the International Medical Congress, "is never stationary. To be stationary while all around is in movement, would be practically to retrograde. But movement does not necessarily mean advance. The general direction of the movement may undoubt-

edly be forwards, but the factors of that movement do not equally tend to progress."

We have entered upon a new era in surgery; we have given up much that was laid down as law in years gone by; and I cannot help but think that a retrospect made from time to time would sift the wheat from the chaff, the good from the bad, and enable us to retain what is useful and to put aside what is worth nothing.

What, then, are the lessons we should learn by a consideration of this period of surgical history? To what are we indebted for the great commotion, or progress—whichever view be taken of it—in the surgical art? To anesthetics and antiseptics, taking the latter in the widest sense of the term.

No one can realize, except those who have witnessed it, the great increase in the number of cases in which anesthetics are employed, not only for operative, but still more for diagnostic purposes, and a great improvement in accurate diagnosis is the result. For this purpose I think we should do well to have recourse to it oftener. How different tumors and joint diseases appear when muscles are completely relaxed! How many mistakes have consequently been avoided; and how many more might have been avoided, if, after the administration of the anesthetic, a careful examination had been made.

But is there nothing to be said on the other side which we might well lay to heart with advantage to our patients? Familiarity with them has led us too be too careless in our examination of patients before their administration. Instead of the careful examination of patients before the day of operation as well as at the time, the latter is made often in a very hasty manner, with considerable bustle and noise going on in the theatre. To this fact, I think, may be ascribed the more frequent deaths from chloroform which have occurred in recent years. Another danger of anesthetics has been, and still is, that operations are now dawdled over, and not so quickly performed as they used to be; and we have not sufficiently realized the part result of this in the success or failure of our operations. A clear and accurate diagnosis is not now thought as necessary as it was formerly, and operators have consequently not as definite an idea of what they are going to do. So far as it is possible, an operation should be well conceived and clearly sketched in the mind of the operator.

In considering the influence of antiseptics upon the surgery of our time, it should be considered in its widest sense; not in the limited sense

to which the term "Listerism" is applied. Mr. Lawson Tait, Mr. Savory and Dr. William Roberts, have proved clearly that healthy living tissues cannot be successfully inoculated with septic bacteria—they cannot grow in them; and clinical experience has proved the same. From the so-called antiseptic treatment has come increased cleanliness of instruments, hands, wards, and air; increased attention to drainage; but these points were already being successfully carried out when the antiseptic treatment was floated, under, what I believe to have been, a false idea of safety. We have, however, learned that we may go further than was done in former days, and in many cases with advantage. We have learned to dress our wounds less frequently; to expose them less.

But while chloroform and antiseptics have had their advantages, have they done no harm? I think they have. What a terrible tale would abdominal sections tell, were they all recorded *accurately*, after the able method of Sir Spencer Wells! How often have they been done unsuccessfully! I am not alluding to ovariectomy, for that is one of the few successes of the last twenty-five years—a success founded upon a rock, which neither the winds of fashion nor the fickleness of the English people will ever shake. I am alluding more particularly to the exploratory operations for the relief of internal strangulation; for the relief of pain; for caries of the spine; and also to those cases where portions of the stomach and intestines have been removed, gastrostomies performed, etc., etc. As Mr. Erichsen puts it, "Will the surgery of our time record 'surgical triumphs or operative audacities?'" May I substitute the word "atrocities?"

Far be it from me to say that these operations are wholly unjustifiable. I have sinned—in my opinion—many times. But is it not time to pause and consider whether they are justifiable; whether they are successful sufficiently often to continue them; and to try and perfect our diagnosis, before we make this a permanent operation. Syme, fifty years ago, used the word gastrostomy and condemned the operation; and I think we are bound to have stronger reasons than we have at present for running counter to the judgment of one of the greatest surgeons of the century.

The St. Bartholomew's Hospital Reports (1884) record twenty-one abdominal sections, with nineteen deaths, exclusive of ovariectomies.

Osteotomies are another result of anesthetics and antiseptics. They have, without doubt, been wonderfully successful; time will show whether they are permanently so. Time will show whether McEwen's or

Ogston's operation is the better ; whether we had better let crooked tibiæ alone, or what we had better do with them. But are there no accidents, sometimes leading to death, of which we hear nothing ? Mr. Langton, of St. Bartholomew's, has, all honor to him, published one. I know of others ; and it is highly probable that the popliteal has been wounded both in Ogston's and McEwen's operations on the femur. I have had two ununited compound fractures of the tibiæ in the same child—made by myself—with necrosis (they have united since I wrote this paper), which have caused me the greatest misery. A boy on whom I performed Ogston's operation, with the strictest Listerian precautions, is still under my care, having had pyemia and an empyema. Would not both these children have had happier lives and better prospects of success in life with their crooked legs and without the operation ? Have we realized the extent of the calamity which it is to growing children to have a serious illness and prolonged confinement in bed ?

With regard to the treatment of diseases of bones and joints, more particularly the hip, the knee, and the tarsal bones, are we where we were twenty years ago ? With regard to the hip-joint and the tarsal bones, I think we are. The recognized modes of treatment of the hip-joint have failed. I do not mean in every case, but in the majority. I think excision of the head of the femur has failed because enough bone has not been removed, and it has not been resorted to early enough ; but so far as I know at present, it is the only mode of treatment with any chance of success, except in the early stages. Excision of tarsal bones or gouging them out may also be classed amongst our failures ; and I would urge a more frequent resort to Syme's operation.

Excision of the knee-joint has established its position in spite of the prophecies of Syme and others. I am inclined to think we ought to try more frequently for a movable joint and removal of the diseased portions of the bone only. I see occasionally a girl, whose knee-joint I excised four or five years ago, who has got good movement, and can walk comfortably several miles a day. I am inclined to think that in the rage for conservative surgery years ago, we lost sight of the fact that prolonged illness in youth often leads to serious constitutional mischief in after life even though the local ailments may be cured, whereas, if amputation had been performed, a moderately active life might have been pursued. If it is right to amputate the thigh in a case of disease of the knee-joint, why not at the hip and ankle for similar diseases ? I believe the first Hey was more successful in these cases than we are now.

The same failure seems to me to have occurred in cases of strangulated hernia. We are often still without any certain guide as to whether to operate or not. Unnecessary operations are still performed, and thousands of operations must have taken place in that time.

While in the treatment of internal cancer, we have been called upon to witness great commotion, if not progress—while in the treatment of mammary cancer, we are urged to clear out all the glands of the axilla, so that nothing be left likely to be infected—a strange inconsistency has arisen with regard to osteoid cancer, especially with regard to the lower end of the femur; and an attempt is being made to run down the time-honored rule of amputating at the hip-joint.

The current literature of the day has begun to harrass the treatment of wounded arteries, and we gather thence no fixed rules for treating wounded posterior tibials, ruptured popliteals. The laws of G. J. Guthrie have been questioned, and an attempt has been made to urge the ligature of the main artery at a distance from the wound, a treatment fraught with danger to the patient and disappointment to the surgeon, and only very rarely successful.

What a deal of commotion, without progress, has there been about the ligature of arteries, the temporary ligature of Dix, the temporary forceps of Nunnally, acupressure, torsion: all have had their day, and all have practically given way to the ligature. Ambrose Pare is still triumphant.

Every department in surgery has been harrassed and unsettled; no one knows better how much has been done in this way than the unfortunate man who has to lay down laws for the students in lectures: for in the very outset, with regard to the treatment and dressing of an incised wound, the treatment of a fracture, there are no rules, no laws; each man does that which is right in his own eyes, and there are almost as many different methods of treatment as there are clinical teachers.

Each hospital has its own particular way of treating broken bones. We have the same miserable sequelæ, ankylosed joints, edematous legs, pain, thickening, want of power, as formerly; and no one stops to think if anything can be done to prevent their occurrence.

Oh, that several workhouse medical officers would write a book on the Sequelæ of Hospital Surgery! Such a book, with a hospital surgeon's account of his mistakes, would do more to advance surgery than the publication of so many successful cases. The treatment of empyema is now one of the burning questions of the day; and we find men advocating

the removal of a portion of, not one rib only, but of four or five; and we are asked to consider the propriety of draining pulmonary vomicae, and the removal of portions of lung. "Are these surgical triumphs or operative audacities?"

In the operations on the kidney, in the substitution of lithotrixy at one sitting for lithotomy, I think we have got real and permanent improvement, as well as in the draining of irritable bladders (first adopted thirty years ago by Paget, of Leiceister), and the removal of vesical tumors; but, on the other hand, doubts are being thrown upon the ordinary treatment of stricture and enlarged prostate. The use of the silver catheter is condemned, and a scare has been set up about catheter fever.

The medical treatment of surgical diseases is practically *nil*. Iodide of potassium, syrup of iodide of iron, and a little opium, form the bulk of the drugs used, and mercury has been abandoned in obedience to the mischievous report of the Edinburgh Commission.

Gynecological surgery is equally disappointing: the removal of ovarian and uterine tumors has been satisfactorily justified; but what about displacements of the womb, abortions, and some smaller ailments? Do we know at all when these displacements produce symptoms or not? Do two medical men ever agree on that point? Pessaries are introduced by us all, and now a warning note has been sounded by our German colleagues that pessaries, morally and physically, are wholly bad. Will any attempt be made to settle this question? I guess not, if we may judge from past history.

In a deal that is now called new, and brought forward as instances of progress, we are now only returning to the modes of treatment suggested and practiced in days gone by. The ligature of the sac for the radical cure of hernia was many years ago practiced by the elder Teale. Cystotomy for irritable bladder was introduced by Paget. The kidney was successfully removed twenty five years ago; osteotomy was performed twenty-four years ago.

To sum up, I am inclined to think that, in future, we shall find surgery stepping in and dealing successfully with ruptured bladders, perforating ulcer of the stomach, and kidney disease; but I do think we ought to make a stand against performing large operations on internal cancer until we know more about their laws of recurrence. I think we ought to watch with very great jealousy the results of our osteotomies, our abdominal sections, and drainage of pulmonary vomicae. We ought

to try to find out what is the best treatment for spinal disease and diseases of bones and joints in their early stages; to invent some more satisfactory way of treating fractures; and to publish more of our unsuccessful cases.

I hope no one will go away with the impression that I am hostile to improvement—that I wish to stand still. Nothing is further from my thoughts; but it does seem to me that we are going too fast; that we are harrassing and unsettling many branches of our art without improving them; that in other branches we are standing still; and in some we are retrograding. Our time will show great commotion and surgical audacities. Will they prove to be progress and surgical triumphs?

LIQUID ERGOT IN CHRONIC GONORRHEA. Dr. N. V. Speece, of Quincy, Ohio, and J. Harvey Craig, of Mansfield, Ohio, both speak very highly of injections of "liquid ergot normal" (Park, Davis & Co.,) in chronic gonorrhea. The injection is used once or twice daily, the ergot being diluted with four times its bulk of water.

RESORCINE IN THE TREATMENT OF EPITHELIOMA.—Dr. Rubino Antonio reports a case of epithelioma developed on the side of the nose. The tumor was the size of a pea, but seemed adherent to the bone, and was surrounded by an inflamed zone of considerable size, the skin being to a great extent involved. An operation not being thought advisable, Rubino decided to employ resorcine. The tumor was washed twice a day with permanganate and an ointment applied composed of fifteen parts of resorcine to twenty of vaseline. Suppuration ceased almost immediately, the tumor diminished little by little, and at the end of five months there was only a small white circular scar visible.—*Journal de Med. de Paris.*

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OBSTETRICS.

ACUTE INFANTILE BRONCHITIS.—(*Prof. J. Lewis Smith.*)—The inflammation has extended to the minute bronchial tubes: the mucous membrane of these tubes is hyperemic and swollen, and actively secreting. On account of the small size of the tubes, many of them become occluded by muco-pus, which acts as a ball-valve, allowing the escape of air upward from the alveoli, but preventing its entrance into them. Hence the alveoli connecting with these closed bronchioles become less and less distended with air, undergoing partial collapse, and some of them pass into a state of complete atelectasis. This occurs most frequently in the posterior and depending portions of the lungs.

Another equally serious pulmonary complication often occurs. I refer to catarrhal pneumonia. The inflammation in its progress downward in the most severe forms of the disease, passes from the bronchioles to the adjacent alveoli, usually in more places than one. With the occurrence of this complication, the symptoms are aggravated, the suffering increases, and the prognosis is obviously the more unfavorable the greater the extent of this complication. Broncho-pneumonia thus occurring is indeed one of the most dangerous diseases of infancy, and one that requires the utmost vigil on the part of the physician, and the most skillful use of remedies, to save the life of the patient. The respiration in severe bronchitis is greatly accelerated, numbering 60, 80, and even 100 or more per minute, and each inspiration is usually accompanied by a moan. The pulse is in a corresponding degree accelerated, and is often feeble; the countenance is anxious and indicative of suffering, and the patient restless.

In this form of bronchitis the indications for treatment are: 1. To promote expectoration, and prevent clogging of the tubes; 2. To diminish the inflammation, and prevent its extension; 3. To strengthen the action of the heart and prevent exhaustion.

In employing measures to fulfill the first indication, it should be borne in mind that the cough is useful in expelling the mucus, and that patients never do well with severe bronchitis that do not cough often. When asked by parents to prescribe something to diminish the cough, I inform them that the safety of the patient depends on the strength and frequency of this symptom, and that it would be dangerous to put a stop to it by the use of opiate or other medicines, and I now very seldom combine an opiate with the cough mixture for severe infantile bronchitis. If

the infant be allowed to cough every five or ten minutes, and the cough be rendered as loose as possible by appropriate remedies, it will do better, according to my observations, than when the cough occurs at longer intervals. If it requires sleep, give medicine separately once or twice daily, as in the following formula for a child of one year.

℞ Liq. opii compositi (Squibbs) gr. xij.
 Potassii bromidi - - - 3j.
 Syr. rubi idæi (raspberry) - ʒss.
 Aquæ - - - ʒiiss.

M. Sig. Dose, one teaspoonful.

I have seen much harm done by employing stupefying agents which, while they produce sleep, also cause suspension of the cough, upon the strength and frequency of which the safety of the infant depends. The very prevalent opinion among the laity that the cough does no good to the infant unless mucus is ejected from the mouth, needs to be corrected. In order to obtain their full co-operation, I often find it beneficial to explain to the mother or nurse the process of expectoration in the infant, so that they understand that the tubes are freed from mucus as effectually when it is swallowed, after the cough, as when it is received upon the handkerchief.

Among the agents to fulfil the first indication mentioned above—that of promoting expectoration with the least possible loss of strength—the first place must be given to the ammonium salts, of which the two in common use are the carbonate and the muriate. The carbonate is both a stimulant and expectorant, but its irritating property is such that it should not be prescribed in a larger dose than one grain to the drachm; a larger dose frequently repeated may produce gastritis, especially if there be little food in the stomach. It has been known to produce gastritis in animals when administered in considerable quantity, and its irritating action on the fauces can be noticed by anyone who swallows a solution of two or three grains to the drachm. The Curator of the Foundling Asylum has noticed in the cadaver the ill effects of the more irritating ammonium preparations. In one instance in which the aromatic spirits of ammonia had been employed, it was supposed with sufficient dilution, the extent and severity of the gastritis were such that it seemed as if this agent might have hastened the fatal result. The preferable way of employing this valuable agent, to prevent its irritating action upon the stomach, is to prescribe it dissolved in water, and order each dose administered in a tablespoonful of milk. The muriate does not possess the irritating prop-

erty of the carbonate, and it can be safely administered in double or treble the dose of the latter, and at short intervals. It is therefore, I think, to be preferred to the carbonate in most cases of severe bronchitis, except at an advanced stage, when an active stimulant of the heart is required.

In this connection, I will state my conviction that the ammonium salts, whether the carbonate or muriate, are not given in sufficiently frequent doses in the practice of most physicians, in severe forms of the disease which we are now considering. If there be marked dyspnea, and urgent need that the mucus be expectorated from the tubes which it is obstructing, I think that the effect is better if the dose be administered every half hour instead of every second or third hour. Half-hourly doses are not inconveniently given if the vehicle be milk.

The muriate of ammonium may, like the carbonate, be administered in milk, but the following is with me a favorite formula :

R. Ammonii muriat. - - ʒj.
 Syr. bal. tolut. - - ʒij.

Fifteen drops, which contain one grain of the muriate, should be given to an infant of three months, and thirty drops, or two grains, to an infant of six months. Physicians, in my opinion, often defer too long the use of the ammonium salts, using for the first days depressing remedies instead. The infant suffering from dyspnea, and requiring a strong and frequent cough to expel the mucus, may, according to my observations, take the muriate from the first day of the sickness with benefit; and every half hour or hour when it is awake. No harm can result from this agent in frequent doses, and for several days, such as might result from the carbonate.

The ammonium salts tend to increase the frequency of the cough, perhaps by the slight irritation which they produce upon the fauces in the swallowing. The muriate may be employed so long as an expectorant is required, and usually with as much benefit as can be derived from any drug.

As regards those other common expectorants which have long been employed, particularly senega and squills, those have been better observers than myself, who have witnessed any marked benefit from them.

It is so necessary, as a means of relieving the dyspnea, to assist the infant to expel the mucus with which the tubes are clogged, when the respiration is much embarrassed, that an emetic is sometimes proper. One should be selected which causes little exhaustion. The syrup of

ipecacuanha may be employed, given with an alcoholic stimulant, as brandy or whiskey. Infants a few months old I have sometimes temporarily relieved by removing with the finger or a swab the mucus that collected upon the fauces. This simple operation produces a forcible cough, and sometimes vomiting, by which a large amount of mucus is expelled.

The necessity of sustaining the strength of the patient, and, at the same time, of reducing the fever, has led to the employment of quinine by many, perhaps most, physicians in the treatment of severe infantile bronchitis. I cannot say that I have noticed any marked reduction of temperature from its use in bronchitis or broncho-pneumonia, but it has seemed to me that it has been useful as a heart tonic. Much harm may, however, be done by employing quinine in the treatment of infants, by the use of doses too large. In the adult, according to the sphygmographic observations of Dr. M. Putnam Jacobi, while quinia in a dose of five grains increases the strength of the heart's contraction, a dose of twenty grains enfeebles the contractile power of the heart in a marked degree. According to Stille and Maisch, "Poisonous doses occasion dyspnea and noisy respiration, which is also jerking, interrupted, retarded, and finally arrested." (*National Dispensatory*.) A dose too large, therefore, would be likely to produce just such symptoms as occur in severe broncho-pneumonia. To an infant aged one year, with this disease, I do not give a larger dose than one-half grain to one grain of the sulphate of quinia, every fourth hour, as in the following formula :

R. Quiniæ sulphat.,	-	-	-	gr. xij.
Ext. glycyrrhiz.,	-	-	-	ʒss.
Syr. pruni Virginianæ,	-	-	-	ʒij.—Misce.

Quinine, however, administered to an infant is very likely to cause vomiting from its bitterness, a result which I do not regret in the treatment of capillary bronchitis, because it causes the expectoration of considerable mucus. The second or repeated dose is usually not vomited. It is difficult to appreciate the beneficial effects of quinine in this disease, but that it does increase the contractile power of the heart seems probable.

If the temperature rise above 103° , if the infant have a full and strong pulse and flushed face, and if the lungs are not involved, or but slightly inflamed, antipyrine may, according to my experience, be safely administered, in proper dose, and with beneficial effect as regards the febrile movement. It should not be administered at stated intervals, but according to the temperature, so that, perhaps, only one or two doses daily may be sufficient. When the lungs are implicated, and the patient

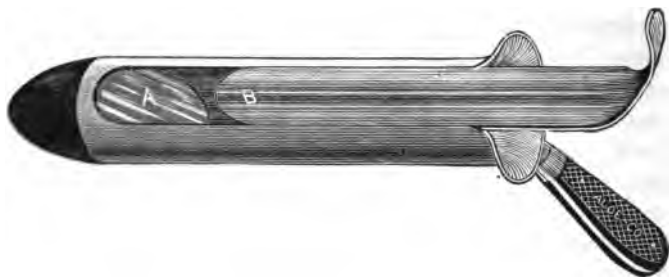
has severe broncho-pneumonia, I have seen such pallor from a single dose of antipyrine, in one instance, that I did not dare to repeat it. It seems to me, therefore, that there should be a careful discrimination in regard to the cases in which it should be employed, so that, while vigorous infants, with severe bronchitis, without pneumonia, or with but slight pneumonia, are benefitted by its use, feeble infants, with weak pulse or with extensive pneumonia, and young infants, incur too great risk to justify the employment of this agent, until its exact therapeutic effects are more clearly ascertained.

When the pulse is becoming more rapid and feeble from the extent and severity of the inflammation, the use of the digitalis is indicated as a heart tonic. Not infrequently in severe bronchitis, with the minute tubes clogged with muco-pus, the heart is taxed to the utmost to carry on the circulation. Digitalis may furnish the needed assistance by increasing the contractile power of the ventricles. It is, therefore, an important remedy in a large proportion of cases of this form of bronchitis. Two drops of the tincture of digitalis may be given every second hour to an infant of eighteen months, during three or four days, or longer, if the action of the heart be oppressed so as to require it. But no one of the medicines which I have mentioned is more urgently needed in severe infantile bronchitis than alcoholic stimulation. It may be employed at an early stage when the heart begins to fail, without fear of increasing the inflammation. A rule with me is to give two or three drops of brandy or whiskey for each month in the age of the infant after the third month. It should be given hourly, or each second hour, by day and by night, when the infant is awake.—*Weekly Medical Review*.

NEW INSTRUMENTS.

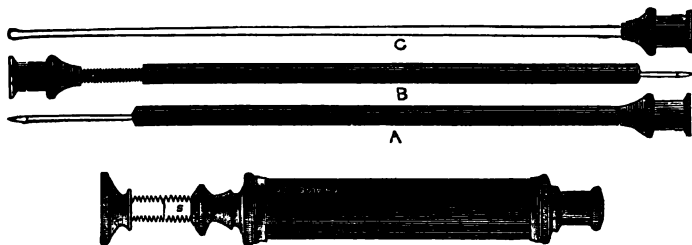
RECTAL SPECULUM FOR HEMORRHOIDS.—The treatment of internal hemorrhoids by injection has become an established operation, almost to the exclusion of the knife, ligature and cautery: the latter operations being not only not devoid of danger, but also so painful as to require an anesthetic. The treatment by injection is essentially painless; there is no loss of blood; it is almost absolutely safe, and the result is as sure and as permanent as by any other method.

Heretofore, however, there has been no speculum well adapted to the operation. But this want is now supplied by one devised by Aloe & Co., of St. Louis.



As seen in the cut, the speculum is about the same as the Ashton, with the point a trifle more conical, to allow of an easy introduction. The slide B is shown partly withdrawn. The mirror A, placed at an angle of 45° , besides acting as a reflecting surface, prevents the mucous membrane from becoming caught as the instrument is withdrawn. The point of the speculum is made of hard rubber, so as not to make the instrument too heavy. The speculums are made in three sizes, the smallest being $\frac{3}{4}$ of an inch in diameter, by 4 inches long; the medium, $\frac{7}{8}$ of an inch by 5 inches; the large, 1 inch by $5\frac{1}{2}$ inches. The advantage claimed for this speculum is, that the smallest part of the mucous membrane can be exposed to the exclusion of all other parts. Price, for a single speculum, \$5; for a set of three \$13.50.

As a companion to the above speculum, the same firm has devised a syringe, the cut of which is given below.



The instrument consists of a silver syringe made to hold 30 minims, one sharp injecting needle A, which has an outer canula, or guage, B, by which the sharp injecting point can be made longer or shorter, at the option of the surgeon. The point C is made of pure silver, with a probe end, and can be used to advantage in the exploration of sinuses, etc. The injecting needle is of gold, making it non-corrosive to the action of any fluid that may be used. The rest of the instrument is made of silver. Price, in morocco case, \$6.00.

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COMMUNICATIONS.

SYMPATHETIC OPHTHALMIA.

BY C. F. CLARK, M. D., LECTURER ON OPHTHALMOLOGY AND OTOTOLOGY IN STARLING
MEDICAL COLLEGE, COLUMBUS, OHIO.

Read before the Central Ohio Medical Society.

The means by which one eye, when the seat of inflammation, may communicate with the other to cause a similar or even more severe inflammation, has not yet been fully explained by the pathologists. Of the various theories of communication by means of the ciliary nerves, by the sympathetics and by the optic nerves, each has a greater or less array of facts and some strong evidence in its favor.

The object of this paper is to recite a few cases which have come under my observation and which have some bearing upon this important subject, but more especially to show the importance of an early enucleation in those cases where an already useless eye is the cause of symptoms in its fellow. That physicians do not always appreciate the full importance of this subject is evinced by the number of cases of blindness from sympathetic ophthalmia to be seen throughout the country. When consulted by patients of this kind from our State institution for the blind, I have been struck by the number to whom the idea of enucleation had never been even suggested by their attending physician, and in whom

such an operation, if done early in the case, would, in all human probability, have saved one good eye.

Of the four cases which follow, the first two, both the result of traumatism, were seen while acting as assistant in the out-patient department of Wills' Eye Hospital, Philadelphia, and the others in St. Francis Hospital in this city.

Case First. This patient I saw at frequent intervals during a period of nine months, and it may be taken as a fair instance of the occurrence of sympathetic ophthalmia in spite of all treatment, and of the preservation of the remaining eye by enucleation, though it was seriously involved even to the extent of a decided optic neuritis. Thomas McG., aged twenty, a tobacco stripper by occupation, was admitted to the out-patient department of Wills' Hospital on the twenty-seventh of December, 1882. He gave a history of having been struck a few hours before in the right eye with a piece of glass and dried putty, while removing a broken pane from a window. On inspection a recent rupture was discovered about two lines in length just below the middle of the cornea, and there was decided opacity of the lens. There did not seem to be much pain at this time, but a solution of atropia was given him, a few drops of which were to be instilled into the eye three times a day, a bandage was applied, and he was directed to report frequently for observation. Being a boy who was obliged to work for his living, this attendance was not as faithful as it should have been, and at the end of two weeks he reported, complaining of great pain in the eye. There was evidence of severe inflammation in the ciliary region, the lens had swollen, and part of it escaping through the ruptured capsule, filled the anterior chamber with lens matter. The patient was admitted to the hospital, sent to bed, a corneal incision was made by Dr. Harlan, and the loose lens substance was removed.

January 12th, 1883, two days later, the cornea and iris were found to be inflamed, and the anterior chamber partly filled with pus. The pain was severe. The following treatment was adopted: Hot stupes were applied frequently, cups were applied to the temples, morphia was given at night for the relief of pain, and a rapid mercurial effect was produced by the administration of calomel, gr. $\frac{1}{2}$ every two hours.

January 17th, 1883, cornea of the right eye in the vicinity of the wound extensively infiltrated with pus.

As late as February 19th, 1883, no signs of involvement of the left eye. Vision full 20-20 and accommodation normal.

March 28th, 1883, right eye greatly improved, but still tender on pressure. Left eye still unaffected.

April 18th, 1883, four and one-half months after the injury, the patient, who was discharged from the hospital some time ago, returned with an acute attack of *conjunctivitis* in the *left eye*. Vision, however, still continues normal, 20-20. R. Acidi boracici, gr. x; sodii biboratis, gr. v; aquæ 3j, was given as a collyrium with direction to instill gtt v. t. d. and report frequently for observation.

April 30th, 1883, vision of left eye now reduced to 20-30, but accommodation is still good. There is some sensitiveness on pressure in the ciliary region, and there is a circumcorneal zone of congestion. The ophthalmoscope reveals congestion of the retinal vessels and swelling of the disc indicative of beginning optic neuritis. The patient was again admitted to the hospital, and the right eye was removed at his own request, his father having objected when the operation was proposed earlier in the case. Upon examination of the eye-ball the following state of affairs was found: Cornea, iris, ciliary body and lens capsule matted together, but no evidence of recent, acute inflammation in the ciliary region. Vitreous humor clear. Engorgement of retinal vessels with decided neuritis and swelling of the optic disc.

May 9th, 1883, left eye improving, but optic nerve decidedly congested. Margins of the disc still blurred and indefinite. Region of the macula lutea normal.

May 18th, 1883, Vision still only 20-30.

October 1st, 1883, the patient was again seen. The eye was doing well and vision had continued normal.

In this case all treatment failed to prevent the occurrence of sympathetic ophthalmia, but, even though well established, enucleation checked the progress and saved the other eye.

Case Second. Bridget K., aged 37, a housekeeper by occupation, appeared at Wills' Hospital, April 25th, 1883, with the following story: Two weeks ago, while at her work sewing, she was struck in the forehead with one blade of a pair of scissors. A slight cut was the result, leaving a scar which is still to be seen. Since that time she had had intense pain in and about her *left eye*, but was unaware of any serious damage having

been done to it, and expressed great surprise when Dr. Harlan informed her that the cornea of the left eye was cut across diagonally from below upward and outward. The above injury was evidently caused by one blade of the scissors while the other penetrated the forehead; but it is remarkable that she did not feel it at the time. On close examination the following state of affairs was found to exist: A white cicatrix extending from below upward and outward through almost the entire diameter of the cornea. Iris engaged in the wound at both ends. Extensive iritis. Fundus can not be seen. Vision in left eye, = 0. R. E. = 20-30. She was admitted to the hospital and the following means were adopted with the object of giving her the benefit of whatever chance there might be of saving the ball if not the sight. Hot applications were made use of at frequent intervals. Anodynes were given for pain and atropia applied. Later, the immediate symptoms having been relieved, the patient was allowed to return to her home.

May 9th, 1883, she again appeared with purulent iritis and hypopion in the injured eye.

June 1st, 1883. The above symptoms yielded to treatment. Pain lessened and vision of right eye is unaffected, being still 20-30.

July 8th, 1883. Vision in the right eye apparently failing slightly. 20-30 doubtful. Accommodation also defective.

July 20th, 1883. Vision in right eye (20-40?) still more diminished and accommodation undoubtedly failing. Unmistakable sympathetic irritation. Tenderness on pressure. Enucleation advised.

July 22nd, 1883. Left eye was enucleated, after which the patient made a good recovery.

This case furnishes another illustration of an unsuccessful attempt to save a damaged and useless eye.

Case Third. Mr. E. G. Spurrier, aged forty-one, was brought to my office in the spring of 1884, by Dr. Newton, of New Straitsville, complaining of increasing dimness of vision, pain, tenderness and photophobia in his left eye. His right eye was lost by ulceration of the cornea during an attack of smallpox from which he suffered while in the late war. The ball was shrunken and the cornea, iris and lens were contracted into a cicatricial mass, but please note that *there was no evidence of inflammation at the time he made his appearance.* Upon examination of his left eye the following condition was found: Conjunctiva of upper lid red, thickened and granular, cornea hazy with a large ulcer near the upper margin, ciliary zone deeply injected and the iris sluggish in its

movements. He was urged by both Dr. Newton and myself to have the right eye removed, but refused. He was at this time very much reduced in general health by the constant pain and anxiety in regard to his eye. Tonic treatment was prescribed. A solution of atropine, gr. iv to ʒj was given, a few drops of which were to be instilled into the eye three times a day, and he was directed to make frequent applications of cloths wet with water as hot as he could bear. In addition to the above a colyrium, consisting of *acidi boracici* gr. x., *sodii biboratis* gr. v. to f ʒj was given to be used from time to time as a disinfectant and cleansing wash to the lid. The patient was warned, however, that he ran a great risk of losing his only remaining eye by opposing the operation.

A few weeks later he returned, his nerves very much shattered by the constant pain, his sight becoming more and more dim from day to day and his left eye in an extremely irritable condition. His request now was that he should be admitted to the hospital and that I should remove the right eye, and by all means save the left if possible.

A vacillating course like the above is the one generally pursued by patients who are the subject of sympathetic ophthalmia, and unless the physician is firm and decided in impressing his own opinion upon the patient, his weakness, and the patient's timidity, must be held accountable for the result. It behooves a physician under such circumstances to be thoroughly understood by his patient; to have a clear idea in his own mind as to what should be done, and if the patient refuses, to wash his hands of all responsibility in the case. In the case we are now considering the patient was told that he had missed his best opportunity, but as the deeper structures of the left eye were not yet distinctly inflamed, there was still some hope for the eye. He was placed under the influence of ether, taken before the class, and the eye removed. The stump healed without the slightest accident, the pain soon left the other eye, and, after some weeks' treatment, made necessary by the ulceration of the cornea and the granular condition of the lid, he was allowed to return to his home in New Straitsville.

In July, some three months after the operation, when he called to be fitted with a glass eye, I found his sight had steadily improved up to that time, and the eye had been free from pain. A few days ago I again saw this patient and the eye had given no trouble.

This case and the one which follows illustrate how an eye which has been lost through inflammation, and in which there is a contracting cicatrix, or deposit of newly formed connective tissue, may, without showing

any sign of irritation in itself, cause violent pain and even inflammation in the other eye, threatening its very existence as an organ of vision.

Case Four. Mr. S., aged about forty-five, a section hand on the C. & H. V. R. R., Corning, Ohio, as a result of ulceration of the cornea occurring during an attack of smallpox, from which he suffered many years ago, lost the use of his left eye. The globe had continued to contract since that time, till at the time of his appearance it was no larger than a small hazelnut. For some weeks he had suffered with severe pain in the right eye accompanied by dimness of vision, deep injection of the conjunctiva of the ball, and granular inflammation of the conjunctiva of the upper lid. This condition of affairs had existed for some time when the patient, suffering greatly, and in a weak, nervous condition, made his appearance at my office in the latter part of June, 1884, with the request that he should be admitted to the hospital for treatment. I suggested to him that removal of the left eye would probably be found necessary, and he gave his consent, but on close examination I found such an entire absence of symptoms referable to this eye, there being no tenderness *even on deep pressure*, that I resolved, inasmuch as there appeared to be no immediate danger, to do what I could to save it. The patient was given tonic treatment and anodynes for his pain; atropine was instilled, hot applications were made systematically, and every means at my command were resorted to, but with only partial success. The hot applications gave some temporary relief, as did also, and to a greater degree, the extraction of blood from the temple by means of Heurteloupe's artificial leech, but in spite of all these means tried faithfully for several days, no permanent benefit was obtained, and the patient's general condition was not improved, but rather the reverse. He was placed under the influence of ether, the left eye was removed, and though to an ordinary examination no possible source of irritation could be discovered in the enucleated eye, immediate relief was followed by a rapid recovery from the sympathetic symptoms in the remaining eye.

Please note the points of resemblance in the two cases: Both had suffered years before with small-pox, and, as a result of the ulceration of the cornea, perforation had taken place, followed by the matting together into a cicatricial mass of the cornea, iris and lens. The ball in each case was contracted. In each case the affection of the fellow eye was developed without any sign of irritation in the contracted ball, and yet in both cases immediate relief followed its removal.

Remarks. These cases, gentlemen, may, doubtless, appear to you

to contain nothing startling. They merely illustrate an old principle of which you may have read; that of the plucking out of an offending eye and casting it from you, in the fear of certain dire consequences. I claim nothing new in their pathology nor original in their treatment. But, of one fact I have been convinced, and that is that many practitioners so far fail to recognize the importance of this intercommunication between the eyes that, unless a marked inflammation is present, or some outward sign of disease in the offending eye brings the subject to their attention, they will allow one eye to cause the hopeless destruction of another before they will see the necessity of calling a halt. And it is to this one point that I would like again to call especial attention: The eye causing the trouble in its fellow may at the time present no symptoms of active disease whatever.

BEFORE AND AFTER TREATMENT.

"You know how it is yourselves."—JOB.

VERY ILL.

Name, Oh, doctor! name your fee!
Ask—I'll pay whate'er it be!
Skill like yours, I know comes high;
Only do not let me die.
Get me out of this, and I
Cash will ante instantly.

CONVALESCENT.

Cut, Oh, doctor! cut that fee!
Cut, or not a dime from me!
I am not a millionaire,
But I'll do whatever's square;
Only make a bill that's fair,
And I'll settle presently.

WELL.

Book, Oh, doctor! book your fee!
Charge—I'll pay it futurely.
When the crops all by are laid,
When every other bill is paid,
(Or when of death again afraid)
I'll pay it—grudgingly.

F. L. J., in St. Louis Medical and Surgical Journal.

DR. CLOUSTON, of Edinburgh Asylum, Scotland, writes: "I am safe in saying that no man indulges for ten years continuously, even though he was never drunk in all that time, without being psychologically changed for the worse. And if the habit goes on after forty years, the change is apt to be faster and more decided. We see it in our friends, and we know what the end will be, but we cannot lay hold of anything in particular. Their fortunes and work suffer, and yet we dare not say they are drunkards, for they are not. It all depends on the original inherent strength of the brain how long the downward course takes. Usually some inter-current disease or tissue degeneration cuts off the man before he has a chance of getting old. I have seen such men simply pass into senile dementia, before he was an old man, from mild, respectable alcoholic excess, without any alcoholism or preliminary outburst at all. And I am sure I have seen strong brains in our profession, at the bar, and in business, break down from chronic alcoholic excess, without their owners ever having been once drunk."—*Jour. of Inebriety*.

WHEN an inebriate suddenly develops mania which continues for some time without cessation, some head injury or sunstroke will be found in the history. If the mania is preceded by a stage of depression and melancholia, the prognosis is grave. If the mania comes on gradually and seems to be dependent on the spirits used, yet keeps on when spirits are removed, serious trouble may be anticipated. If the mania goes away and returns again without any external cause, some state of physical exhaustion produces it. If the mania is violent and destructive, more debility will follow than if mild and delusive. Deliriums of grandeur and power are not grave where they are transient, but when they grow in intensity and duration, grave lesions of the central nervous ganglia are indicated. The manias of inebriety should always be studied with great care.—*Jour. of Inebriety*.

EXPERT TESTIMONY. Judge C. C. Fuller, of Mecosta Co., in the case of "State of Michigan vs. Vanimmans," decided, when a physician refused to testify on the ground that the evidence would be expert testimony, "after many years' study and observation, I decide that a physician's knowledge is his stock in trade, his capital, and we have no more right to take it without extra compensation than we have to take provisions from a grocery without pay to feed the jury. The Court rules that the witness is not compelled to testify."

MEDICAL EDUCATION.

BY A. L. KNIGHT, M. D., WEST COLUMBIA, W. VA.

A Paper read before the Ohio Valley Medical Association.

At the last meeting of this Association it was made my duty to prepare a paper upon Medical Education, with which I complied, by giving my own private views, drawn from various hints and short sketches from educators in all the various branches included in a liberal literary education. But with all my gleanings I failed to find any hints upon physical training and the early teaching by the objective method; the importance of which I tried to impress in my former paper.

To bring the points which I then made fresh to mind, and especially for the benefit of those here to-day who were not then present, I will briefly epitomize that paper.

I first pointed out the kind and quality of the human family, or rather of certain members of our race, upon whom it was proper and advantageous to society to confer a medical education. My selections, had I any choice in the matter, would be made from the hearty, well-developed, physically and mentally, kind and benevolent sons of the industrious and laboring classes of the country. I used the word "country" in its specific sense, in contradistinction to our cities and larger towns, the downy nestings of dudes and imbeciles.

Secondly, being offered a student who has had the advantages of a scientific education, both by objective and subjective training, lay before him the privations and constant labor in a life time of study and the inadequate remuneration for arduous duties of a physician's practice, without much recognition for the sacrifice of his health and comfort, the censure from the ignorant and irresponsible, the debarrment from much of the social pleasures, and finally, the fact that he will be laid prematurely in the grave, with no effects worth dividing, or sighs or tears except from his paupered wife and children, who fall heirs to his old books and instruments, worth five per cent. of what they cost. When he has been told all this (and it has not been much overdrawn), then if the candidate determines to be a doctor of medicine, give him a little encouragement by exhibiting the pile of text books he is expected to master. Though it is not necessary to tell him, as a further inducement, that you have not mastered them yourselves, as this might encourage him to read them less attentively, merely putting in the time required, to get his latinized sheepskin, and cause him prematurely to enter the "slaughter pen."

Thirdly, I ventured the opinion that the low status of the financial condition that attach to many portions of our extensive country almost precluded the inducement of the expenditure of the time and money necessary for the highest culture in a medical education, and yet it seems cruel that human beings, merely for want of funds and good sense, should be compelled to employ those who are very limited in medical lore. But then, the impecunious of sparsely settled neighborhoods have, as a rule, the best of hygienic surroundings, and consequently are more or less exempt from those occult and frequent diseases common to cities and the larger manufacturing towns: and hence escape those neurotic ailments, brought about by dissipations, immoralities and foul air which attach to the latter. Thus, however cultured the physician may be, if it be his lot to practice among the former, he would in time become rusty in his knowledge of the more hidden diseases, and ultimately play the role of a mere routinist. Taking that view of the case, we should not be too exacting in the standard of medical education while the wants of the country do not demand it, and the people not able to afford it. But it would be well if those who practice in such locations were loyal to their profession, and each continued to improve the few talents intrusted to him by his alma mater. But, sad to say, many of them become mercenary, ply their avocations as a means of acquiring money, fame and popularity, estrange themselves from fellowship with professional brethren, do not add to, or receive any of the advantages that go to make progress; but feeling their deficiency, hide it behind a veil which none but their learned brothers can see through, and by their reticence attempt to hide it from even these. I have no doubt any of you can point out just such characters, who ape the showmen by putting all the attractions on the outside of the canvas, and none within. But this only proves how many might have been successful merchants, lawyers, artisans and farmers, who have been lost to society by their conversion into that kind of doctors. I may be putting it rather strong when I assert that I have known these mercantile doctors to button-hole the ministers and leading members of every denomination, join every secret order that would take them, take great interest in the Sunday School, and invariably have a case of midwifery on hand, at every meeting of the medical society.

But, you ask, what has all this to do with medical education? I might say very little, for doctors of that character are not surcharged with medical education. Yet it is possible for one to be a very fine

scholar in all the collateral branches of science necessary as a foundation for a medical education. In fact, some of this class are blessed with an intuitive knowledge of human nature, with great powers of adaptation and urbanity, so as to inspire great expectations and confidence in their patrons. These are qualities which are laudable, and add materially to the success of any practitioner ; but the contemptible element lies in the inefficiency of some of us from want of a thorough medical education, not being able to fulfill our part of the implied contract. Of all rascalities, false pretense is the most ignoble. Thieves may steal our effects in the dark, which is bad for us ; but far worse is it if our effects are taken in broad noon-day, and our confidence stolen and prostituted.

I will give in this paper the branches of learning in which a student of medicine should be educated, viz: Latin and Greek, and at least one modern language besides his own ; mathematics in all its branches ; chemistry, botany, natural philosophy, natural history, philology and belle-lettres. I place Greek and Latin at the head of the list, because many leading physicians say they are absolutely necessary to an accomplished physician, although admitting that there are, exceptionally, excellent men who have not a knowledge of those languages. Billroth says that while the Latin has ceased to be an international language, yet those who can read and converse in it are, as a rule, the best physicians, and that their intellectual powers are more improved by such knowledge than they would be by mathematical attainments. Billroth, and those whose opinions coincide with his, may be correct ; but in my own experience I have found the mathematicians, in contradistinction to the classically educated, to be the more astute and rational thinkers, though in regard to polish and style of expression, the latter appear to the better advantage.

Chemistry comes next in importance in the curriculum of medical education, being the rival of mathematics and the classics in drawing out the mind from its dark and superstitious nature to expanded rationality, and in unfolding the facts and laws, or truths, of nature's grand laboratory. This will become more apparent as I proceed.

I think there should be more time devoted to anatomy, not merely in its surgical aspect but as a basis for physiological investigations. Physiology is the science of the functions of the anatomical structures ; hence the folly of trying to learn the function of an organ of which we have but an imperfect idea, and which can not be perfected until we have cut and divided it in every possible direction. A mere outline description

gives about as much real information of an organ as does a physical geography give of countries, rivers, lakes and mountains which we have not seen. Anatomical structures should be carefully examined by the eye for a knowledge of their mechanism, and microscopically for a correct understanding of all their parts. And as far as possible this kind of investigation should be had on living tissues, as in that manner we learn their various functions and are thus led into the science of physiology, which treats of the normal function of every organ in the economy. Until the student is thoroughly acquainted with the physiological action of the various organs and tissues of the body, he is entirely unfitted to take up the next branch in medical education, which is pathology, or diseased anatomy: for unless he be familiar with a healthy functional action, how can he be aware of any departure therefrom? If he be not a good pathologist, then he must fail as a diagnostician, and one should never attempt to treat any disease unless he knows what he has to treat. While it requires years of patient study to be a pathologist, this fact offers no excuse to medical schools for accepting a mere skimming over of this branch under the impression that it will be acquired afterwards in the text book on the practice of medicine. That is to say, pathological training should be had, to the fullest possible extent, prior to clinical instruction. I do not expect that, in our day, there will be anything like a rational medication; yet a knowledge of the things to be treated, and the physiological action of the means used to bring about a healthy reaction, whether of medicinal or other agents, certainly tends in that direction.

But without clinical experience our knowledge of all the foregoing branches would avail us nothing practicable: a thorough clinical education is the crowning wreath that should decorate every educated medical gentleman. I need not remind the older practitioners who, notwithstanding their possession of a very liberal education in all the other branches of medicine, groped for a decade in the dark, and who, from this fact, are ever incredulous as to the ability of the younger ones, that this idea has become so fixed in the minds of medical educators, that no medical college, worthy of the respect of the medical profession, neglects to give its students as much clinical instruction as possible; so that the young graduate of to-day is as efficient in practice as were his older brethren after ten years of practice.

Clinical study is inexhaustible: other branches may to a certain extent be mastered, but not clinical investigation, which is far from an

exact science ; every clinician has his special color to lay upon the dark canvas of diseased action, and no two figures are fac similes, though all of the various thousands bear a striking resemblance. Hence the necessity of a multitude of close observers to enable the practitioner a choice of the middle or conservative ground, in his application of medicinal remedies in the treatment of any given disease. But since the library of the ordinary practitioner is usually limited to a few text books, his opportunities are thereby circumscribed within their limits and his own observations, which can be extended by a judicious selection of the best medical periodicals of the present day. And let me say we should be proud of our American medical journalism.

There is yet another potent way of extending our clinical information, and that is by frequent society meetings, where we can exchange views, garnered from more text books than any one of us possesses, as well as from the limited observations we each and all have made, and the consequent judgments upon them.

HOW TO SHARPEN A KNIFE.—Dr. O. H. Allis, in the *College and Clinical Record*:

I always like to tell you things that will be of practical value to you. One thing that you should learn now, and which will be of advantage to you all your lives, is how to sharpen a knife. Many men have achieved great distinction in surgery who could never sharpen a knife. The knife should be ground so as to be slightly concave, and should be of good steel. Unless the knife is of good tempered steel, and unless you have a good oil-stone, you will become discouraged, and think that you have no skill or cannot learn. If the knife is very dull, you grind it by putting it on the stone and carrying it backward and forward; if the stone is not a good one, a little ground slate-stone dust may be sprinkled on it. In order to get a fine edge on it, you do not want much strength. Use only two or three fingers, and draw the edge of the blade toward you in a manner just the opposite from what you do on a leather strap; then turn the knife and carry it in the opposite direction. In this way a good edge will be obtained. Where a stone is not available, I have often used a piece of board with fine dust sprinkled upon it.

SLEEPLESSNESS.—Dr. J. Milner Fothergill says of sleeplessness: "One broad rule to bear in mind is this: Opium is the agent where insomnia is due to pain; chloral where it is due to a high blood pressure in the arterial system; the bromides where there is any peripheral irrita-

tion. Opium, having a pronounced effect upon the sensory portion of the brain as an anaglesic, is the drug par excellence in sleeplessness due to pain. Whenever there is a morbid condition in tense tissues, as syphilitic node for instance, pain on going off to sleep is set up by that dilation of the system generally which is essential to brain depletion. The effect of pain is to arouse the brain into wakefulness. Where such a complication exists, it is well to combine the opiate with some potent depressent of the circulation, as antimony or aconite. In many cases a full dose of alcohol is sufficient for the attainment of the desired end."
—*Brief.*

At the Samaritan Hospital of London, Drs. Bantock and Thornton are said, by Dr. J. D. Emmet, to be equally skillful operators, and have about equal success. One ascribes his results to strict Listerism, while the other regards carbolic acid and corrosive sublimate deleterious to the patient, and uses only water directly from the main. They are alike in their absolute cleanliness, and this combined with their skillful operating is probably the essential element of their success. He also says that Tait, in all his operations, allows no one to touch an instrument, no one to touch a sponge, and no one to approach the abdominal cavity but himself. He is absolutely clean, is nurse, assistant, as well as operator. Hence his unrivalled success.—*Detroit Lancet.*

"Good morning, gentlemen," said the doctor, as he walked into the newspaper office, "is the city editor in? Ah, yes, I see. Mr. Huntup, there was an accident on Fremont avenue this afternoon that I thought you would like to hear of. Mrs. John Peduncle was thrown out of her carriage and sustained a compound fracture of the right clavicle. She was taken home and medical aid summoned. Her injuries were skillfully attended to, and she is now resting easily. You might say that I was called, and have charge of the case."

"By the way, doctor," said the advertising manager, looking up from his books, "I would like to insert an advertisement for you in the *Banner*. I'll let you have it a year for \$30 an inch, payable—"

"Sir," interrupted the doctor with a scowl, "I never advertise. It is contrary to medical ethics. Good day, gentlemen."

COLUMBUS MEDICAL JOURNAL.

OBSTETRICS.

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HORSFORD'S ACID PHOSPHATE,

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Dilute Phosphoric Acid.

The attention of the profession is respectfully invited to some points of difference between Horsford's Acid Phosphate and the dilute phosphoric acid of the pharmacopeia. Horsford's Acid Phosphate is a solution of the phosphates of lime, magnesia, potash, and iron in such form as to be readily assimilated by the system, and containing no pyro- or meta-phosphate of any base whatever. It is not made by compounding phosphoric acid, lime, potash, etc., in the laboratory, but is obtained in the form in which it exists in the animal system. Dilute phosphoric acid is simply phosphoric acid and water without any base. Experience has shown that while in certain cases dilute phosphoric acid interfered with digestion, Horsford's Acid Phosphate not only caused no trouble with the digestive organs, but promoted in a marked degree their healthful action. Practice has shown in a great variety of cases that it is a phosphate with an excess of phosphoric acid that will better meet the requirements of the system than either phosphoric acid or a simple phosphate. "Phosphorus," as such, is not found in the human body, but phosphoric acid in combination with lime, iron and other bases, *i. e.* the phosphates, is found in the bones, blood, brain and muscle. It is the phosphates and not the simple phosphoric acid that is found in the urine after severe mental and physical exertions, or during wasting diseases.

We have received a very large number of letters from physicians of the highest standing, in all parts of the country, relating their experience with the Acid Phosphate, and speaking of it in high terms of commendation.

Physicians who have not used Horsford's Acid Phosphate, and who wish to test it, will be furnished a sample on application, without expense, except express charges.

RUMFORD CHEMICAL WORKS,

Providence, R. I.

 BEWARE OF IMITATIONS.

OBSTETRICS.

ITEMS FROM A CLINICAL LECTURE ON CANCER OF THE BREAST.—(Edmund Owen, F. R. C. S., in *Brit. Med. Journal*).—The hereditary influence of cancer has probably been much exaggerated. Sir James Paget expressed the matter to a friend of mine in this way: "If a woman died of cancer, and left ten children to grow up, I should not be surprised if one of them were eventually the subject of cancer; but I should be surprised if two were."

The chief symptom of the disease is this. There is a stony lump in the breast of a woman aged 40 or 50, less or more. This is almost enough for the diagnosis; and if the nipple be retracted against, or the skin be dimpled upon, the mass, the evidence of scirrhus is abundant. But retraction of the nipple and dimpling of the skin are not enough of themselves, for they may occur after mammary abscess, from shortning of certain fibers which extend from the breast to the integument. Nor is hardness by itself a sufficient sign, for sometimes a cystic growth or a chronic abscess is surprisingly hard.

Sooner or later, the axillary glands will be enlarged; but as, in chronic cancer, it may be years before such enlargement can be detected through the floor of the axilla, and as the glands may be enlarged in simple inflammatory disease of the breast, the enlargement is not a characteristic symptom of scirrhus. Moreover, if only the sternal part of the gland be affected, the lymphatic invasion will be in the anterior mediastinum, and out of the reach of palpation.

Operation.—Two semi-elliptical incisions should be made, wide of suspicious skin, and, passing on each side of the nipple, should be directed along the lower border of the pectoralis major. If the horns of the incisions be made slightly to cross each other, the pointed ends of the piece of skin to be removed will need no further touches of the knife. It matters not which of these incisions be made first, the upper or the lower. Whilst making them, the surgeon should give no thought to the subsequent approximation of the edges of the wound. His duty is to remove the skin abundantly. If the wound cannot be closed by suture, at least it can heal by granulation.

The fingers are then hooked round the breast, and are made (with the occasional help of the knife) to draw out the mass. The entire breast should be taken away in every case, even if only a small part of it be implicated in the disease, as it should also when the nipple is removed for

the intractable eczema to which reference has been made. Bleeding vessels having been promptly seized with the catch-forceps—a dozen pair should be at hand—the incision is prolonged through the floor of the axilla, and the contents of the space are examined.

Axillary Glands.—So far as my experience serves, it used to be the practice, not very many years ago, to refuse to operate for cancer of the breast if glandular enlargement could be detected in the armpit. But in this respect, as in many others, surgery has of late undergone a great change. The clearing out of axillary glands is now recognized as a very necessary part of the operation for mammary cancer. Like many other surgeons, I make it now my practice to lay open the axilla, whether enlarged glands have previously been detected or not. Indeed, unless the glandular enlargement be considerable, it is impossible to be certain about it until the space is opened up and the fingers are introduced. The axillary fascia having been incised, the fingers and thumb are introduced; every gland that can be felt, whether enlarged or not, should then be torn out. No pains should be spared over this part of the operation; in carrying it out, the intercosto-humeral nerve is generally seen, and the fingers work along by the cords of the brachial plexus, and by the axillary vessels themselves. It is hardly necessary to say that the knife is not there employed, except in very severe cases, as where a mass of glands has effected important and firm connections. Apparently, this interference with the interior of the space does not retard convalescence. The arm being fixed to the side directly after the operation, the chasm is promptly effaced. The deep parts of the wound should not be disturbed by sponging; this interferes with the deposition of the film of coagulated lymph, which checks bleeding and is a barrier to absorption. The surface may be irrigated with a warm solution of mercuric chloride before the wound is closed. It is advisable that all bleeding should have ceased before the suture is applied. Provision is made for drainage, by a separate opening through the skin of the most dependent part of the chasm; that is, usually, not far in front of the angle of the scapula. The other end of the tube is brought through another special opening at the front of the chest. The long wound is then closed by continuous suture of catgut, and dressed with wood-wool sewn in gauze bags. The hand is brought to the opposite shoulder, and the bent arm is firmly fixed across the chest, and over the dressings, by a soft towel, secured with safety pins.

On the next day a much smaller tube is introduced; and, after this, the less that the part is interfered with the better. Professor Roddick, of

Montreal, first advised me to use the continuous suture in amputation of the breast, and I am extremely pleased with it. One or two of the stitches can be cut, if necessary, without the rest of the suture giving way. As soon after the operation as possible, the patient should be got out of bed. I now make it the custom to have her sitting by the bedside in an easy chair on about the fourth day. No harm can come if the arm be secured against the chest in the way already explained.

As regards the site of the recurrence, my experience is that it is almost invariably in the scar, rarely in the axilla, and scarcely ever in a more distant part of the body. In several instances, I have found a hard deposit in that scar which marked the anterior incision for the drainage-tube, and which was an inch or more from the edge of the wound, and still further from the original situation of the diseased mass. Sometimes the recurrence is manifested by small hard nodules in the neighboring skin, the scar itself being apparently healthy.

It has been remarked by a thoughtful surgeon, that he who values his peace of mind will never operate for cancer of the breast. That same surgeon would, however, be the first to admit that the mental ease of the practitioner is not to count before the physical well-being of the patient. It is afterwards a great comfort to a patient to feel that she has had the privilege of operation, even though there be a recurrence of the disease.

As time advances, it will probably be found that operative surgery can be of yet greater service in rendering cancer a strictly local disease. If so, the first advance will likely be made in dealing with the enlarged cervical—supraclavicular—glands, which are infected after invasion of the axillary lymphatics, through the apex of the axilla and beneath the clavicle. Although they can be pulled down by the fingers and the forceps in the armpit, especially if, at the same time, pressure be made from above the clavicle, still, the better way will probably be to extract them by a direct incision at the root of the neck, after the clearance of the armpit.

After operation, the patient should present herself for inspection by the surgeon at regular intervals, say of six weeks or two months; so that, in case of recurrence of the disease, no time may be lost in operating again. Then, in case of suspicious fullness about the axilla, or of hardness about the scar, the cicatrix may be widely removed, and the armpit again examined, and, if necessary, cleared out. To have operated once should not be suffice; time after time must the attack be renewed, whilst

there is prospect of operating through uninfected tissue—of getting beyond the disease.

The value of this treatment is shown in the case of Mrs. M., whom you have just seen. She was sent to me on May 10th, 1876, in order that I might carry out the treatment by injection of acetic acid. For seventeen months a tumor had been growing in the sternal side of the right breast. It was very hard, and the skin was dimpled over, and adherent to it in several places. There were some enlarged axillary glands. For seven weeks the acetic acid treatment was carried out, but without any avail, and operation by the knife was agreed upon. At the time of its performance, the enlarged glands were removed from the armpit. In the early part of 1877 there was a return in the pectoral region, and a former colleague swept away all the diseased tissue with a knife. In April 1878, the patient was fairly well, but soon after there was a recurrence of the growth. I operated again; and I performed a fourth operation in the beginning of 1879. After this last operation, she secured a pension from the Putney Hospital for Incurables.

As I examined her just now, I found the extensive cicatrix perfectly soft and movable, and without tenderness. The armpit, moreover, is perfectly clear of enlarged glands, so far as one can determine by careful examination. It is now more than seven years since the last operation, and the woman seems to be absolutely cured of her disease.

CASTRATION IN MENTAL AND NERVOUS DISEASES.—The October number of *The American Journal of the Medical Sciences* contains a symposium by the leading authorities on this subject in the United States, Great Britain, and on the Continent. Sir Spencer Wells maintains that the operation of oophorectomy, or the removal of normal ovaries, is one which may be advised in some cases of uterine fibroids and in uncontrollable uterine hemorrhages. That it is to be resorted to in certain malformations of the genital organs, deformities of the pelvis, and accidental obstructions of the vagina. That the right to use it is very limited in cases of ovarian dysmenorrhea or neuralgia, and only when they have resisted all treatment, and life or reason is endangered. That in nearly all cases of nervous excitement and madness it is inadmissible. That it should never be done without the consent of a sane patient, to whom its consequences have been explained. That the excision of morbid ovaries and appendages should be distinguished from oophorectomy, and ought not to be done without the authority of consul-

tation, as in most other cases of abdominal section. That in nymphomania and mental diseases it is, to say the least, unjustifiable.

Prof. Hegar holds that castration is indicated in a psychosis evoked or maintained by pathological alteration of the sexual organs, and in a neurosis originating from the same source, as soon as this imperils life or hinders all occupation and all enjoyment of life. The indication is also present when that disease represents only one casual factor in the genesis of the affection, without the removal of which a cure is not to be thought of. The remaining causes of suffering must be in this case accessible to treatment. Other milder methods of treatment must have been tried previously without success, or, as in the case of many small tumors of the ovaries and tubes, must from the outset give no promise of success. Castration must actually affect the cause which occasions or keeps up nervous irritation. The operation will thus be of use when a degenerated or dislocated ovary represents the irritative focus, or as soon as a greatly swollen and retroflexed uterus presses on the sexual plexus and the organ is brought into a state of atrophy. Castration promises success when the bleeding and anemia occasioned by a fibroma play an important part in the maintenance of a psychosis, so that a cure does not appear possible without getting rid of that evil; but castration is absolutely no universal remedy for any neurosis originating from a genital organ disorder, or kept up by the same. The cessation of ovulation will avail nothing if the irritation starts from the nerves which are compressed in a shrunken cicatrix of the broad ligament, or elsewhere in a cicatrix of the pelvic connective tissue.

Dr. Battey writes that he has performed castration for the relief of mental and nervous disorders, which may be divided into three classes: oophoro-mania, oophoro-epilepsy, and oophoralgia. He uses the terms oophoro-mania and oophoro-epilepsy instead of hystero-mania, and hystero-epilepsy, because clinical experience teaches him that these disorders are dependent upon a nervous irritation proceeding from the ovaries and not from the uterus. He finds the disorders existing (*a*) in cases in which he recognizes organic disease of the ovaries, and is not able to recognize any organic disease of the uterus; (*b*) in cases of uterine as well as ovarian disease, when the diseased ovaries are removed, the nervous disturbance disappears notwithstanding the fact that a displaced or diseased uterus may remain. In his experience the time required for the disappearance of nervous disorders, after removal of the ovaries, has been quite variable. In general, epileptiform manifestations have ceased at

once. Some of the cases have required for a time the tranquillizing effects of the bromides to ward off threatening symptoms, whilst others have needed nothing. His cases of mania have all been quite chronic, and the improvement has been slow. In oophoralgia, in a few instances, the cure has been immediate and permanent. In the majority it has been slow and gradual; and in others, nothing has been gained for even two years after the operation. In a few the long established opium habit has proved a complete bar to recovery.

In his cases which have had two years or more to test them, seven have been cases of oophoro-mania, of them one was cured, and four improved; nine were cases of oophoro-epilepsy, all cured; twenty were cases of oophoralgia, and thirteen were cured and three improved.

METHOD OF INDUCING LABOR.—Prof. Tibone suggests a modification of the method of Krause, which is, as is known, the introduction of an ordinary sound into the uterus, leaving it there until labor is established. Tibone's method is as follows: After taking all antiseptic precautions, the cervix is brought into view by means of a speculum and then a special kind of sound is introduced. The author prefers the plain English bougie, No 10 or 12. The bougie is held a moment in a warm mercurial solution and is gradually softened; it is then introduced into the cervix, and slowly and gradually pushed up until it has entirely disappeared inside the womb. There is then placed upon the mouth of the womb a large tampon of cotton soaked in an antiseptic solution; the patient may then get up and keep about until the appearance of labor. This method is perhaps a trifle slow, but is sure, and on account of the softness of the instrument used there is no exposure to violent rupture of the membranes or to serious injury to the placenta. The author has used this method repeatedly, and always with satisfaction.—*L'Union Medicale*.

SUMMER DIARRHEA.—In the large class of summer diarrheas of children and adults, with griping in the bowels and flatulence, the use of listerine, in doses varying from ten drops to a teaspoonful, (with or without water) has a most salutary and pleasing effect. It can be administered at short intervals after eating, as soon as regurgitation, distension or acidity occurs. Its action in arresting excessive fermentation is prompt, besides it exercises a decided sedative influence on the mucous membranes of the stomach. The thymol, menthol, and boracic acid which, with the quota of alcohol necessary to their proper admixture, form the principal elements of Listerine, lend to this compound a special value in this class of cases.—*New York Medical Journal*.

SURGERY.

SELF-REPOSITION OF HERNIA.—A new method of reduction of strangulated hernia by manipulative measures is published by Nicolaus, of Baden.

In order to demonstrate experimentally the inadequacy of all the measures of taxis, already abundantly shown in practical experience, the author suggests that a section of intestine, about a yard long, be drawn through a piece of rubber tubing, about two inches long, of a calibre that will permit a pretty thick catheter to be pushed through the tube within the lumen or at the side of the gut. If water be poured into the upper portion of the gut, it becomes highly distended above the tubing, but not a drop flows and escapes from the free lower end of the intestine. Pressure upon the distended portion will cause it to burst, mayhap, but no fluid will escape by these manipulations. However, only a light traction upon the lower empty segment is followed by a free flow of water; the same result follows if the catheter be pushed upward through the tubing.

In strangulation the same conditions obtain; the distended gut lies outside of the outer hernial aperture, the empty gut inside the inner hernial aperture. In taxis we compress the filled and distended section, which, as our experiment demonstrates, is not a good method of promoting the escape of the fluid, and which may lead to the bursting of the gut. Gentle pressure upon the distended section, and alternately upon the tubing, alone leads to a gradual emptying of the fluid; this last procedure of alternating pressure upon the strangulated gut and upon the strangulating channel is the mode by which taxis affords relief. Contrasted with this procedure, the ease with which, by traction upon the empty end, the escape of the fluid and the liberation of the gut is accomplished, is most striking.

These considerations, and the well-established observation that hernia, which is irreducible, *intra vitam*, by taxis, can be reduced after the abdomen is opened, *post mortem*, by a most gentle traction upon the intra-abdominal loops, led Nicolaus to seek methods of reduction in which traction should take the place of pressure.

He refers to the rude methods by which reduction through the weight of the intestines alone was attempted; thus the method of Corvillard of suspending the patient by the feet; the method of suspending by hands and feet; the wheelbarrow method, the inclined plane, etc. The barbarity and fruitlessness of these methods is well known, and they

offend all feeling of surgical tact. He points out that in all these positions the intestines cannot act by their force of gravity, because either the intestines come to lie upon the posterior walls of the abdominal cavity or meet with the resistance of the insufficiently relaxed anterior parietes. A position, therefore, must be adopted that relaxes the abdominal wall most perfectly and throws the hernial apertures as high up as possible over the level of the most dependent part of the cavity. This position is the knee-shoulder position, or Sims' lateral recumbent position upon the healthy side, with the pelvis well elevated.

In these positions it may be clearly shown, that not the force of gravitation alone is a factor favorable to the reduction by traction, but, much more so, a most interesting physical phenomenon that is so established. Namely in these positions the intra-abdominal pressure becomes negative, that is to say, sinks below the atmospheric pressure. This circumstance obtains in the indicated positions to a much greater degree than in the knee-elbow position, of which Hegar says: "In the knee-elbow position the viscera on the lower level, the thorax, the intestines, the parietes, must exercise a traction upon the parts at a higher level. This leads to a reduction of the abdominal pressure. It becomes lower than the atmospheric pressure. This can be demonstrated to be the case by introducing a catheter into the bladder. Generally the atmospheric air audibly rushes into the bladder through the catheter."

Nicolaus' method, then, consists in the exercise of traction upon the engaged intestine, by establishing a high degree of negative intra-abdominal pressure, and thus permitting a full exercise of the force of gravitation. The patient is made to kneel upon the bed, and throws himself upon the shoulder corresponding to the healthy side. The thighs are to be kept at right angles to the plane of the bed. Bladder and rectum should be emptied, and gentle taxis may be exercised. If necessary the knees may be still more elevated by placing them on a firm bolster. Rotation outward of the thigh of the engaged side may also be made; thus, as Hyrtl states in his *Topographical Anatomy*, the outer aperture of the inguinal canal is made more patent.

In support of his theoretical deductions Nicolaus reports seven cases of strangulated femoral and inguinal hernia that yielded under the indicated treatment.

The circulation of the blood in the incarcerated loop is certainly much favored by the aspiration exercised by the negative pressure. In cases Nicolaus found that persistence in maintaining the positions

indicated led to a good result after a few hours. A change from the knee-shoulder to Sims' position is advisable, when the patient should have the rest and comfort that an alteration of position brings.—*Weekly Med. Review.*

COMBINED TUBULAR AND CAPILLARY DRAINAGE OF LARGE WOUNDS.—The great practical importance of the subject of drainage leads me to make a few remarks in relation to its use in large wounds.

The *methods* may be divided into two—first by tubes, and secondly by capillary action; and the *materials* vary in each. I reject the older mode by tents and their equivalents, as with modern antiseptic methods they are practically abandoned. For modern surgery demands that we shall strive for union by first intention and without suppuration—results unattainable by the older means just named.

The tubes employed are either rubber (usually fenestrated) or decalcified bone. They have one marked advantage, viz., their large calibre and free discharge. Hence they are especially fitted for securing the escape of the more abundant oozing following all large operations or after opening large abscesses. I always keep several feet of such tubing in a bottle of carbolyzed water (five per cent.), and have not found any septic results from their use. They have, however, the disadvantage that if exposed to pressure, as in a joint, their calibre is obliterated. The decalcified bone sometimes is not aseptic and not seldom softens and collapses, especially if kept in carbolyzed oil. Keeping them in glycerine and alcohol, or in the bichloride solution and alcohol, often prevents this. But even then, within a week, they dissolve and no longer act as drains.

The second method is by capillary action. For this purpose either horsehair or catgut or rubber threads are used. They answer well in case the liquid to be drained is thin, but if thick and glairy they fail to act and are useless. Of the three, on the whole, I prefer horsehair (which, after washing, I always keep in carbolyzed water as above), as it is equally unirritating, can always be had, is strong, is not absorbed as the catgut is, and allows the granulations to grow in between its threads.

My special object, however, is to bring forward a method I have used for some seven or eight years which unites the advantages and avoids the danger of both methods. The chief advantage of the tubing is its free discharge. Its disadvantage, in addition to that noted above,

is that if used for any length of time, when removed, it leaves a tubular passage of considerable calibre lined with granulations. This passage if long, as in large wounds, is often apt to close at two or more points in its course, thus penning up the slight discharge and producing retention and suppuration. The disadvantage of the capillary drainage is that it is not fitted to give exit to large amounts of fluid. Its advantage is that it leaves no such tubular passage, but that while giving us the means of introducing tubing for freer drainage, if at any time it is needed, it allows nearly complete healing, even while a few of its strands are still *in situ*. Especially is this of value in larger wounds with long drainage paths.

The method referred to is as follows: When the wound is ready to be closed, a fenestrated rubber drainage-tube and a bundle of horsehair of fifteen to thirty or more strands are both placed side by side in the wound. At the end of twenty-four or forty-eight hours the abundant oozing of bloody serum usually necessitates a redressing, but by this time the first abundant discharge has ceased. Accordingly at the first dressing after the operation I remove the rubber tube, leaving the horsehair in place. If the oozing will probably be small, I often even remove a large part of the horsehair. At the second dressing, say in three to six days, I remove all the horsehair or all but two or three strands. In doing so I always remove the hairs one or two at a time, as the nice adjustment of the surfaces is thus scarcely at all disturbed. At the third dressing, if all has gone well, the last horsehairs are removed and the capillary passage heals within twenty-four hours.

For joints or in other wounds where possible longer slight discharge may take place, the horsehair may be left for longer periods as judgment dictates.

I have used this method in amputation of the breast, often bringing tubing and horsehair out through a button-hole counter-opening in the axilla and treating it as described above. I have used it in a large number of amputations of the upper and lower extremities and in the removal of tumors of the neck and other parts of the body and find it to work admirably.

The same result may be attained by first using the tubing alone, and replacing it at the first redressing by the horsehair, but the pain and the mechanical disturbance of the wound are so much greater than the method above described that I have never found it to answer as well.

Of course for small wounds, only the horsehair is required.

While speaking especially of rubber tubing and horsehair, this method of combined drainage will answer equally well with any of the other materials mentioned, and it is to the method that I particularly design to call attention rather than to the material used.—*Dr. W. W. Keen, in Medical News.*

SOME MOOT POINTS IN THE NATURAL HISTORY OF SYPHILIS.—The *Edinburgh Medical Journal* gives the following summary of this question, as set forth by Mr. Jonathan Hutchinson in the Lettsomian Lectures for 1886:

Mutual Relations of the different Forms of Primary Venereal Sores. No one thinks that there are two forms of syphilis, and no one doubts that there are two kinds of sores. Are they related or independent? That is all we dispute about. The fact that favors the creed of those who think that they are independent is, that the secretion of the chancroid is very contagious, and always produces a sore like itself. This was proved by Bassereau by confrontation. Since then syphilization has abundantly proved his point. It must be remembered, however, that it was done almost exclusively on those who had had syphilis. Here was a fallacy, for the patient might, in consequence of his prior syphilis, be insusceptible of fresh contagion. But the practice was tried by Danielson on a number of lepers who had never had syphilis, with similar results. It might seem that the proof of specific distinctness was here given. It is necessary, however, at this stage to insist that there is an important difference between a specific contagion and a specialized contagion. All inflammatory products are probably, under favorable conditions, contagious, as gonorrhea, erysipelas, and diphtheria, and so on. It is possible, then, that the poison which produces the chancroid is after all only a specialized product of inflammation, and not a specific virus. Many facts seem to support the conclusion just hinted at, and to imply that soft sores are after all an appanage of syphilis. In practice we encounter a great variety of conditions and great differences in course in the "soft" group of venereal sores, and are obliged to conclude that they agree in one feature only—the absence of hardness. The rounded form, punched out and ragged edges, and gray base, are conditions not present in Mr. Hutchinson's experience in one of five of the venereal sores which do not harden. This want of uniformity in conditions is a strong argument against specificity. Another equally strong argument is that the true chancroid on the genitals is seldom

seen, excepting in those who have had syphilis already. In using this argument he by no means wishes to deny that the typical chancroid is sometimes seen in those who have never had syphilis. Mr. Hutchinson thinks all *a priori* probability favors the suggestion that non-indurated sores are produced by the secretion of true chancres, which have been changed in character either by the inflammatory process or by the non-susceptibility of the tissues of the recipient.

Phagedena. All will admit that syphilitic inflammations have a remarkable tendency to become phagedenic. This may occur in all stages of syphilis, and to all kinds of sores.

Hospital Phagedena. Epidemics of this form he believes to originate from cases of syphilitic phagedena. A knowledge of the fact that phagedena usually goes with true syphilis is of much importance for purposes of retrospective diagnosis. While some have assumed that scars on the penis, or its extensive malformation by bygone phagedena, imply the probability of syphilis, others have asserted that they rather favor the belief that the disease was not true syphilis. His vote would go with those who regard them as important, though not conclusive, evidence of constitutional disease. He also regards scars in the groin as presumptive evidence of syphilis.

Second Attacks. In 1839 Ricord said that a person who had once had syphilis was not liable to it again. Up to 1858 he had met with no exceptions that satisfied his mind. In the following year occurred the first case in which he himself witnessed and treated two attacks of undoubted constitutional syphilis in the same patient. It is, Mr. Hutchinson thinks, generally accepted, that second attacks after considerable intervals are not very uncommon; but, at the same time, that Ricord's law holds good in reference to a very large majority.

Incubation Periods. Opinions vary greatly on this point. If by incubation periods we mean, as he contends we ought to do, the interval between contagion and the production of an induration which can be diagnosed, then Mr. Hutchinson believes we shall seldom find it less than five weeks, and more often six. If we date to the first appearance of a sore, then it will be a week or ten days shorter, for the development of hardness takes that time. In the case of a medical man who vaccinated himself in the forearm from a syphilitic infant, the punctures, which had quite healed, became irritable on the twenty-first day, and were well characterized chancres on the forty-first. In another series of vaccination-syphilis, eleven patients received the virus on the same day.

In all the punctures, or vaccine-vesicles, healed ; and in all they became irritable at the end of the fifth week, and were well indurated at the end of the eighth.

Recurrent Chancres of False Indurations. They occur to those who have had syphilis, and usually on the site of former chancres. They occur usually within five years after syphilis. They develop in the retro-coronal fold of the prepuce, and are often wholly without ulceration. They do not resemble tertiary gummata. They are rarely attended by an enlargement of glands, and never followed by constitutional disease.

On Indurations as a Symptom, and on Syphilis without Chancre. In many cases it lasts only a very short time, and is only very doubtfully marked ; in others it may, in size and duration, simulate a new growth. In woman it is often very ill marked, and its characters vary much in relation to the special tissue affected. In some cases no initial lesion can be discovered. These cases divide themselves into two groups—those in which an attack of gonorrhea preceded the constitutional symptoms of syphilis, and those in which no local disease of any kind was observed. Respecting the last it is undoubtedly possible—indeed, in most instances, probably true—that a chancre had been present and had escaped recognition.

Gonorrhea-Syphilis. The frequent occurrence of cases in which syphilis follows what was considered to be only gonorrhea suggests the suitability of recognizing what we might call gonorrhea-syphilis. Mr. Hutchinson quotes cases from several authorities in confirmation of this.

Syphilis conveyed in Vaccination with clear Lymph. A gentleman in our profession vaccinated his own arm repeatedly, and in many places, from syphilitic infants, being very careful on every occasion to use only clear lymph. On the first two occasions he failed, but on the third he succeeded, and three indurated chancres were the result, followed in due course by constitutional symptoms. Had that repetition not taken place, and had a report of results been given to the world after the first two trials, how strong would have been the conviction of all in the truth of the creed, that pure lymph, even from infected vaccinifers, is safe ! The interest of this demonstration does not end with its relation to the practice of vaccination. It proves that the virus of syphilis may exist in a perfectly clear fluid, and in company with that of another specific fever. We know from experiments that if the purulent secretion of soft sores be filtered so as to get rid of pus-cells, it is no longer inoculable. The converse is probably true of the virus of syphilis. The contagion

of the one is pus, that of the other the particulate micro-parasites of a specific fever.—*American Prac. and News.*

LUXATION OF THE ULNA IN COLLES'S FRACTURE.—It is now about fifteen years since Moore, of Rochester, called attention to the occurrence of dislocation of the ulna and its separation from the triangular cartilage in Colles's fracture of the radius. He first observed these complications in the case of a woman, who, in a fit of mania, leaped from a third-story window, and broke her spinal column and both wrists. Four additional cases have been studied by him and have confirmed his convictions that, even when these fractures are the result of ordinary violence, they present the same features of a separation of the triangular ligament from the ulna, rupture of the lateral ligament, and tearing off of a portion of the styloid process of the ulna.

Moore's assertions have not so far secured the consideration they seem to deserve. Indeed, the credit of the discovery of the important relation of the dislocation of the ulna and fracture of the styloid process to Colles's fracture has lately been assigned to another investigator, Mr. Clement Lucas, whose observations were published in *Guy's Hospital Reports* for 1883 and 1884. These observations support the views so long ago expressed by Moore, although they differ from his in certain particulars.

There can be no doubt of the correctness of the statements of both Moore and Lucas. It is, moreover, certain that there is more or less displacement of the ulna from its connections at the wrist, with fracture of the styloid process, in many fractures at the lower end of the radius, in which these lesions are not discovered or even suspected. Moore estimates the frequency of these complications as about fifty per cent., and Lucas found them present in fifteen out of twenty-eight specimens in Queen's College Museum, which he subjected to a careful and critical examination.—*Phil. Med. News.*

INGROWING TOE NAIL.—For ingrowing toe nail M. Lucas-Championniere recommends washing the toe with a five per cent solution of carbolic acid. Local anesthesia is produced and the nail is removed by avulsion and the rim of the bed of the nail is excised. Carbolic acid is again used, and a salicylic cotton wool dressing impregnated with vaseline, containing a fifth of boric acid, is applied; it is then powdered over with iodoform and enveloped in salicylic cotton wool, which is again enveloped in ordinary cotton wool, and finally bandaged. After an interval of three weeks there is cicatrization and the dressing is removed.—*Med. and Surg. Reporter.*

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MEDICINE.

THE HYGIENE OF OLD AGE.*—(Prof. H. C. Wood, M. D., of Philadelphia.)—Within a few weeks the city of Philadelphia has been called upon to mourn the loss of the man who, although very far from intellectually the greatest within her borders, as a citizen was pre-eminently chief. Dying at the age of eighty or eighty-one years, he is universally spoken of as being gathered like a ripened sheaf; yet, within a week of his burial, he was full of mental and physical vigor, and his death at the time was as unnecessary and avoidable as though he had only reached threescore years. A very notable percentage of the deaths of persons who have been successful in life, and have attained beyond the seventieth year, could be, by proper care, long postponed. Failure in life in a large proportion of cases saps vitality, and the man who carries the load of self-knowledge of such failure lives under a persistent strain, whose effects, though usually not recognized, are none the less irresistible. In order to protract an advanced life it is well to understand not only the dangers that beset such life, but the reason why old age has been attained.

The humorist is greatest when underlying his rollicking is the lesson of a great truth; but perhaps few readers, when they enjoyed the broad fun of the "One-Horse Shay," as portrayed by our inimitable Holmes, have recognized the fact that the man who reaches old age does so largely because he has been constructed upon the principles of the famous vehicle "that ran for a hundred years and a day."

Barring accidental deaths from railroad collisions, typhoid fevers, lightning-strokes, and other more or less preventable causes, the man who is so built that he is equally strong in all his parts, lives out his appointed days.

Excessive strength in one part is a veritable source of danger. The athlete perishes because his over-developed muscular system perpetually strains and finally wears out a heart or a lung that was originally constructed for a muscular apparatus of half the power of that which he has artificially built up. The larger proportion of mankind die early on account of some local weakness. It ought to be generally recognized that human age is not to be counted by years, and that in some constitutions the general tissues are older at fifty than they are in other indi-

*Read before the State Sanitary Convention, held in Philadelphia, May 12th, 13th, and 14th.

viduals at one hundred. Many of the cases of so-called neurasthenia, or nervous exhaustion, of men and women suddenly or gradually breaking down at forty or fifty, ostensibly from overwork, are really cases of premature old age, and are to be nursed and treated precisely as other individuals would be who had reached to fourscore years. Moreover, a larger proportion of early deaths are the result of some vital organ being originally endowed with a longevity less than that of the rest of the organism.

The reason that consumption is so often utterly irremediable is to be found in the fact that in not a few cases the lung has reached its allotted term of days, and must die because its vitality is exhausted. If an eye, or other not vital part, fails from lack of vital power, the man exists; but if a lung dies, he perishes.

The result of these lucubrations is to lead us to this point, namely, that the individual who enjoys fair health at seventy-five years of age has probably been built upon the principle of the "One-Horse Shay," and that he should be treated as a wise man would treat such a venerable instrument of progression. He would certainly keep it off Philadelphia cobble-stones, and allow it only to be bowled along some smooth turnpike, and especially would he avoid all jolts and jars which would throw an unexpected strain upon one part. The principle involved in such case is that which is most vital in the treatment of the old,—protection, and especially protection from strain of any one vital part. An old man exposes himself to inclement weather, and especially to a high wind, which suddenly drives the blood from the surface upon the internal organs, and at the same time by its very force checks the enfeebled movements of respiration, which aid in forcing the blood out from those organs. As a result, the man perishes at once, because he has thrown too great a strain upon a weak heart, or, if able to momentarily resist the strain, dies in a few days of pneumonia, due to the congestion of the lung. I have known the sudden shock of good news to strike the old man down, as fatally as the pole-axe fells the bullock, by causing the blood to rush with renewed force through the brain, and tear its way through the weakened walls of the blood-vessels. Again, the violent emotion of a sudden bad news may overwhelm a heart which, with care, would have sufficed for its duties for many years. The young athlete in the boat-race pulls at his oar until he drops from heart-strain, and, if the heart-strain has not been too severe, recovers himself in a few weeks, because the vital elasticity of the heart-tissues is in highest vigor. But

the enfeebled and brittle heart-muscle of the old man, strained in some hurried effort to catch a railroad train, or in some equally unreasonable procedure, has no power of recovery, and rests itself only in death. What is true in regard to the healthy ordinary conditions of the old man is more abundantly true in regard to the diseases of the old. Medicines that perturbate—measures that bring relief through violent local actions cannot be borne, and are not to be employed. At the same time, when possible, it is most essential to arrest at once any incipient disorder in the aged. I knew an old doctor, renowned in all lands, who lived ten years beyond the period attained before by any one of his name, largely because, knowing himself thoroughly, every few weeks he arrested in its inception an attack, which, in a few hours, might have gathered fatal force.

I feel some hesitation in attempting to point out in detail the application of the principles which have just been enunciated, lest this paper may fall into the hands of aged persons, and be substituted for a careful consideration of their individual cases by some skillful medical practitioner.

Every person, when he advances in years, should go over his whole methods of life and personal habits with some wise counsellor, and should adapt his mode of life to the peculiarities of his individual case.

With this warning, it is probably safe to briefly point out some of the more important details in the regulation of the life of old people. The first question is in regard to food. The teeth in old age are, of course, lost, and they should, unless under exceptional circumstances, be replaced by artificial teeth, for the thorough chewing of food is even more necessary in the old than in the young, because in the old the digestive powers are apt to fail. With the best artificial teeth, mastication is apt to be imperfectly performed; hence the food of the aged should be soft and readily comminuted, and especially should it be of easy digestion. Very few old people need stimulating diet; very many are injured by an excess of nitrogenous food. The kidneys, like all other organs, are feeble, and, if meats and other rich foods are used in excess, they greatly increase the strain upon these organs. Milk and milk products, or preparations of breadstuffs cooked with milk, should form a very large proportion of the food of the ordinary aged individual; but individual peculiarities differ so much that personal medical counsel should in all cases be taken, so that the diet may be regulated to the needs of the individual case. Very many old people are hurt by the

use of food in excessive quantity; but little exercise can be taken, all growth has ceased, and the bodily furnaces which make heat are able to destroy but very little of food fuel. Some little time since I had occasion to lecture on this subject at the Philadelphia Hospital, and an assertion that I then made that most old people are more comfortable, enjoy better health, and probably live longer for the use of wine, has met with very severe disapprobation at the hands of some of the profession, whose strong sympathy with the temperance movement dominates their judgment. No valid reasons have, however, so far as my judgment goes, been brought forward to lead me to change my opinion. In the overfed American people the habitual use of wine during youthful or middle age and vigorous health is, we think, an injury rather than a good; but when the powers of life are failing, when digestion is weak, and the multitudinous small ills of feebleness perplex and annoy, one or two glasses of generous wine at dinner aid digestion, quiet for the time being much irritation, and in no way do harm. The sum total of ruin wrought by alcohol in the world is appalling, but it is not lessened by our shutting our eyes to the good that wine properly used may achieve. When in the aged there is a distinct failure of vital power, and especially of digestive power, the call for the habitual use of alcoholic liquors is, in my opinion, imperative. The danger of the formation of any evil habits when a man has crossed the line of seventy is so slight, that the most conscientious physician need not hesitate in recommending the daily use of alcoholic beverages to his patient.

It is, perhaps, not universally recognized, that in numerous cases of various character death finally is due, in greater or less measure, to cold and to an absolute failure on the part of the body to keep itself warm. In the old the heat-making functions are exceedingly low and hence it is that few old people are comfortable in a room whose temperature is less than 80°. It is especially important, therefore, that an abundance of clothes be worn by old people; but the very weight of the clothes oppresses, so that it is important that lightness of material should be combined with warmth. There is no ordinary garment which compares in heat-preserving powers with the buckskin jacket, and, in our climate, every man who passes the seventieth year should furnish himself with such covering. At first the jacket should be only worn when going out of doors; but in very advanced age it should form a part of the habitual underwear. The jacket should be high up in the neck and long in the sleeves, and should be of such a length as to thoroughly cover the abdo-

men. If worn as an under jacket, it should be perforated so as to allow the escape of the vaporous emanations from the body. Whenever there is any tendency to abdominal weakness, in addition to the jacket and the ordinary warm underclothes, an abdominal flannel bandage should be worn. It ought not to be forgotten that the mass of blood of the human body is in the abdominal organs, and that this is especially so when the circulation is sluggish. It is affirmed by authority, that after death all the blood in the body can be put in the relaxed abdominal vessels; hence the importance of maintaining the abdominal warmth, and hence also the good effect in feeble people with pendulous bellies of the bandage, which helps to sustain the relaxed vessels, and thereby maintain the general circulation. The mechanical effects of tight abdominal bandages are well understood by the profession in the treatment of ascites. It is well known that the sudden removal of the fluid by tapping over the abdominal cavity takes away so much pressure from the abdominal vessels as to cause them to relax, and draw the blood away from the heart and lungs and brain in sufficient quantity to produce fainting. It is to prevent this that the patient about to be tapped is bound up, and the bandage continually tightened as the water flows off. The importance of the habitual abdominal bandage is, perhaps, no less although not as universally recognized.—*Annals of Hygiene*.

THE REPORT OF THE AMERICAN CHOLERA COMMISSIONER.—Dr. E. O. Shakespeare, of Philadelphia, who was commissioned last year by the President to investigate cholera in Europe and India, has returned and engaged in the preparation of his official report to Congress.

The investigations of Dr. Shakespeare, comprising anatomical and bacteriological studies, as well as those relating directly to hygiene, climatology, etc., have led him to conclusions concerning the nature and spread of cholera, which, in the main, accord with those enunciated by the German and Belgian Cholera Commissions. He regards the comma-bacillus of Koch as a diagnostic sign of the greatest practical value for the early recognition of the presence of true Asiatic cholera. Irrespective of what may prove to be the real etiological relations of this micro-organism to cholera, he looks upon this discovery of the German Commission as of incalculable practical importance to health authorities, of both local and general governments, whose duty it is to guard the people from the destruction of life and trade which usually follows an invasion of this disease. As to the pathogenic properties of the comma-bacillus,

Dr. Shakespeare has less positive opinions. While he thinks it probable that this microorganism may also be the active cause of cholera, he feels that the proof is not yet absolute and fully convincing.

It is, therefore, evident that the conclusions of the American Commissioner are in opposition to those published by the English Commission, and in conflict with the notions advanced recently by Mr. Cunningham, the late Surgeon-General and Sanitary Commissioner with the Government of India. Indeed, we are informed that, even in India, not one physician in fifty shares the opinions published by the late Surgeon-General.

In this connection it may be mentioned that D. D. Cunningham, of Calcutta, the well-known Indian pathologist and microscopist, has, as the result of his latest laboratory work, fully accepted the claims of Koch concerning the diagnostic characteristics and value of the comma-bacillus. It will be remembered that he was originally heartily in accord with Klein and Surgeon-General Cunningham in their contradictions of the conclusions of the German Commission. Apropos of this important change of opinion, the rumor has reached us that the chief of the English Commission, Dr. Klein, has also found reason to modify greatly his views concerning the diagnostic value of the comma-bacillus of Koch.—*Phil. Med. News.*

CALOMEL AS A DIURETIC.—Dr. D. J. Leech contributes to the *Medical Chronicle* for July, 1886, an abstract of a paper on this subject, by Jandrassik ("Dtsch. Arch. f. klin. Med.," xxxviii, 1886), in which the statement is made that calomel has a powerful diuretic action in cases of anasarca. In one case 330 ounces of urine were passed in twenty-four hours. If purgation is produced, the diuretic action is diminished or lost, and an opiate is called for; yet the author used jalap with the calomel. The explanation given of this action of calomel is, not that it acts on the kidneys, but in some way it causes the absorption of the effusion into the blood, and then the kidneys, provided they are healthy, undertake the work of getting rid of it. "If Jandrassik's views as to the efficacy of calomel are confirmed," says Leech, "the great value of the well-known pill consisting of blue pill, digitalis and squill, will be readily comprehensible."

[Noel Paton has shown that whatever increases the secretion of bile, increases also the amount of urea in the blood. It has long been known that any increase in the amount of urea in the blood causes diuresis. Calomel acts as a cholagogue by being partially decomposed, in the alimentary canal, into corrosive sublimate.—ED. COL. MED. JOUR.]

COMPARATIVE TABLE SHOWING CHANGES IN THE URINE, WITH TWELVE DIFFERENT LESIONS.

DR. WM. H. PORTER, in the *Quarterly Bulletin* of the Post Graduate Medical School and Hospital, gives the following instructive table:

BRIGHT'S DISEASES.		CHEMICAL EXAMINATION.					MICROSCOPIC EXAMINATION.
VARIETY OF NEPHRATIC LESION.		COLOR.	QUANTITY.	SPECIFIC GRAVITY.	AMT. OF ALBUMEN.	THIS REFERS TO BLOOD AND CASTS ONLY.	
1. Acute Parenchymatous Metamorphosis of the Kidney.	Abnormally High.	Very Small.	High. from 1.017 to 1.030.	Abundant.	Early: Hyaline, epithelial, nucleated, and finely granular; small in diameter and abundant. Later: Some coarsely granular and fatty, with large diam.		
2. Chronic Parenchymatous Metamorphosis of the Kidney.	Abnormally High.	Very Small.	High. from 1.015 to 1.030.	Abundant.	Large hyaline, coarsely granular, and fatty casts, and large amount of cast debris.		
3. Parenchymatous Metamorphosis of the Kidney with Pregnancy.	Variable.	Variable, but usually Small.	Variable.	Variable, Trace to Abundance.	All varieties of casts may be met with, even blood casts from the renal obstruction. Early it will resemble No. 1, later No. 2.		
4. Parenchymatous Metamorphosis of the Kidney with Diabetes Mellitus.	Lemon Yellow, but later Pale.	First Large, then Small or Suppressed	First High, 1.015 to 1.030; later, Low; or at last Lower.	At first Glucose; later, trace of Albumen.	None until late in the diabetes, when hyaline casts appear, occasionally a few granular.		
5. Parenchymatous Infiltration Metamorphosis of the Kidney with Wasting Diseases.	Normal or Watery.	Normal.	Normal.	None.	Examination negative.		
6. Acute Diffuse Nephritis.	Abnormally High, Smoky or Bloody.	Very Small or Suppressed.	Low. 1.012 to 1.020.	Abundant, also blood.	Blood and blood casts a diagnostic feature. Early: Small, hyaline, epithelial, nucleated, finely and coarsely granular, in abundance. Later, fatty and larger casts.		
7. Chronic Diffuse Nephritis—large Kidney.	Peculiar Pale.	Constantly Varying sometimes Small, then Large.	Low. 1.017 to 1.010.	Constantly Varying from None to Abundant.	The quantity and variety of casts is constantly varying, at times abundant, at others absent. The constant fluctuation is diagnostic. All varieties may be found during its course.		
8. Chronic Diffuse Nephritis—small Kidney, without Vascular thickening.	Peculiar Pale.	Always below Normal; Small.	High. 1.015 to 1.025.	Usually Abundant and Continuous.	Hyaline, epithelial, nucleated, finely and coarsely granular and fatty casts of all sizes, and in abundance continually. Blood and blood casts occasionally found.		
9. Chronic Diffuse Nephritis—small Kidney, Hyaline thickening of the Afferent Vessels.	Peculiar Pale.	Usually Large, 80 to 100 oz. a day.	Low. 1.010 or Lower.	Abundant and Continuous.	As a rule, no casts are found; but occasionally a hyaline or fatty cast may be detected.		
10. Interstitial Nephritis or Cirrhotic Kidney; Cirrhotic Sclerotic, or Red Atrophy; Thickening of Afferent Vessels.	Nearly like Water.	Very Large.	Low. 1.010 to 1.005.	Usually absent, occasionally a Trace.	As a rule, No casts are found; but occasionally a hyaline cast is discovered.		
11. Gouty Kidney.	Nearly like Water.	Very Large.	Low, 1.010 to 1.005.	Absent or a Trace.			
12. Waxy, Amyloid, or Albuminoid Transformation of the Kidney.	Nearly like Water.	Exceedingly Large.	Low, 1.005 to 1.010 or Lower.	Usually Absent, occasionally a Trace			

As a rule, No casts are found; but occasionally a hyaline cast is discovered,

THE DIAGNOSIS OF RENAL CANCER.—(Dr. Jno. A. Ochterlony, in *Jour. Am. Med. Ass.*)

CANCER OF STOMACH.

1. Vomiting is the rule.
2. Hematemesis, especially in the form of "coffee-grounds," very common.
3. Hematuria absent.
4. Tumor in epigastrium.
5. Tumor small.
6. Tumor movable.
7. Tumor descends with diaphragm.

ENLARGEMENT OF SPLEEN.

1. Absence of descending colon in front of tumor.
2. Border of tumor thin, rigid, smooth, but not rounded.
3. Extends upwards under the ribs.
4. Direction of tumor downwards and inwards.
5. Very movable.
6. History of malaria or leucocythemia.

RENAL CANCER.

1. Generally unilateral.
2. Tumor hard or irregularly soft.
3. Rarely and then imperfectly fluctuating.
4. Tumor permanent.
5. Tumor often of enormous size.
6. Tumor generally fixed.
7. Does not descend with diaphragm.
8. Tumor of rapid growth.
9. Cachexia.

CYSTIC DEGENERATION.

1. Bilateral.
2. Tumor may be large.
3. Tumor movable; it rises and falls with the diaphragm.
4. Runs a rather slow course.
5. No cachexia.

CANCER OF KIDNEY.

1. Generally absent.
2. Very rare.
3. Hematuria generally present.
4. In one or the other flank.
5. Tumor often large.
6. Generally fixed.
7. Does not descend with diaphragm.

RENAL CANCER.

1. Descending colon may be found in front, vertically dividing the tumor in two lateral halves.
2. Border often irregular, nodulated, rounded, not thin.
3. Less so.
4. Downwards toward iliac fossa.
5. Generally almost or quite immovable.
6. Absent.

HYDRO-NEPHROSIS.

1. Generally unilateral.
2. Soft.
3. Fluctuating.
4. Liable to subside suddenly at times, with copious discharge of urine.
5. Not so.
6. Movable.
7. Descends with diaphragm.
8. More slow.
9. Absent.

CANCER.

1. Generally unilateral.
2. Tumor attains an enormous size, much larger than is ever reached in cystic degeneration.
3. Tumor stationary, and does not move with diaphragm.
4. Runs a more rapid course.
5. Cachexia sets in early, and is well marked.

Various uterine and ovarian enlargements have been confounded with renal cancer.

Malherbe relates a case in which cancer of the kidney was mistaken for a fibrous tumor of the uterus. And Dr. Greenhalgh gives the history of a patient in whom a tumor, supposed to be ovarian, acted as a complication in two pregnancies, and the propriety of a removal was about to

be entertained when the patient again became pregnant. She died without obvious cause three weeks after delivery at full term, and the autopsy showed that the supposed ovarian tumor was really the left kidney in a very advanced state of disease. It weighed twenty-seven pounds three ounces. Pregnancy and renal cancer were mistaken for one another when fetal diagnosis was not so well understood and practiced as it is now, but at the present such an error could hardly be made or adhered to for any length of time by an intelligent and careful observer.

RENAL CANCER.

1. Generally unilateral.
2. Develops from above.
3. Tumor hard.
4. Rarely fluctuating.
5. Irregular, nodulated.
6. Loop of intestines in front of tumor common. Dullness to the outside.
7. Aspiration brings pure blood and sometimes cancerous material at point of needle.

OVARIAN TUMOR.

1. Generally unilateral.
2. Develops from below.
3. Soft.
4. Generally fluctuating.
5. Generally smooth.
6. Intestines pushed aside, resonance on outside. Dullness central.
7. Aspiration brings away characteristic ovarian fluid.

Hepatic and renal tumors have not seldom been confounded. Rayer and Frerichs both mention cases in which renal cancer had been pronounced cancer of the liver. It is true the two may coexist, as was observed in one of my own patients; but as a rule, attention to the following points will distinguish them:

Cancer of the liver lies much higher, and generally presents an irregular nodulated border running more or less diagonally across the abdomen; the intestines never lie in front of it. Jaundice is common, hematuria is rare. In renal cancer the tumor occupies a lower point, rises vertically and not so high; ascending colon generally lies in front of it. There is an appreciable interspace between the margin of the liver and the upper border of the renal tumor. Jaundice is very rare and hematuria common.

Many other diseases from which renal cancer is to be diagnosticated can be mentioned only in passing. Hydatids of kidney, perinephritis, psoas-abscess, enlargement of mesenteric glands, abdominal aneurism, ascites, distension of cecum and ascending colon, etc.

The judicious employment of purgatives to empty the bowel, the practice of auscultation and percussion, the use of the aspirator and attention to the history of the case, will generally suffice for a correct apprehension of the nature of the disease.

THE HYPOPHOSPHITES.—There can be no doubt that the hypophosphites now in common use prove beneficial in many cases of pulmonary consumption as well as in other wasting diseases. Whether they play the part of supplying necessary materials to the bodily tissues, or whether, through decomposition, they give out force for carrying on the bodily functions, is not definitely settled. It has been shown by experiment, however, that animals fed on the hypophosphites gain largely in weight over those who receive none—the gain being proportionate to the amount fed, and this indicates that they act the part of constructives. In accordance with this view, Dr. T. J. Mays, of the chest department of the Philadelphia Polyclinic, with assistance of Mr. Kyner, the apothecary, has devised a preparation which has yielded good therapeutic results. Its composition is as follows :

R. Calci chlor.....	gr. 3.
Ferri lact.....	gr. 0.5
Magnesii hypophosph.....	gr. 1
Ammon., “	gr. .05
Potass. “	gr. .05
Sod. “	gr. 1.5
Mangan. “	gr. 0.25
Quin. mur.....	gr. 0.25
Strychniæ.....	gr. 0.01
Acidi hypophosph.....	q. s.
Alcohol	q. s.
Acid. citr.....	q. s.
Syrupi	q. s. ut ft. ʒj. M.

DOSE.—One teaspoonful before each meal and at bedtime, in cold water.—*Polyclinic.*

TREATMENT OF EPILEPSY.—(DR. E. D. FISHER, in *Journal of Nervous and Mental Diseases.*)

In reference to the treatment of epilepsy I depend on the bromides exclusively, usually commencing with thirty grain doses, three times a day.

I prefer, as a rule, the mixed bromides, in the proportion of four parts of the potassium bromide to two parts each of the sodium and ammonium bromide; when cardiac weakness is present, employing digitalis or aromatic spirits of ammonia.

I have not found, as some affirm, that iron acts deleteriously, that is, when anemia is present. Nor does the continued use of the bromides

for years even, in my experience, lead to any mental disturbance; in fact, I find a gradual improvement in this respect whenever I succeed in controlling the disease.

In regard to cure of the disease, in my opinion that is less often accomplished than amelioration of the condition.

HAGER'S CATARRH REMEDY.—The formula recommended by DR. HERMAN HAGER is as follows:

Carbolic acid, 10 parts,
Alcohol, 10 parts.
Water of ammonia, 12 parts.
Distilled water, 20 parts.

Take two ounce, wide-mouthed bottles, fill them to one-third with the above liquid; then introduce a bunch of (absorbent) cotton of sufficient size to soak up all the liquid.

To be used in incipient cold in the head, coryza, chronic catarrh, etc.

A stronger preparation, also recommended by HAGER, is the following:

Carbolic acid, 10 parts.
Oil of turpentine, 5 parts.
Water of ammonia, 12 parts.
Alcohol, 20 parts.

To be used in the same manner as the preceding.

HAGER recommends these as prophylactics against diphtheria. He advises all those who handle and are about patients suffering from diphtheria or phthisis, to place a vial with this *olfactorium* to the nose when they approach the patient.—*Med. Age.*

For *cystitis* and *irritable bladder*, Dr. Hearn gave, at the Jefferson College Hospital:

R.	Sodii bromid.,	℥ss	
	Tinct. hyoscyami,	f℥ss	
	Syrup.,		
	Aquæ, aa	q. s.	ad f℥iv. M.

Sig.—Teaspoonful ter die.

In a case of *infantile eczema*, Prof. Bartholow, besides directions given as to diet, placed the child (aged two years) upon tinct. bella-donnæ, gtt. v, ter die, or sufficient to cause dryness of the mouth. The object in view is to affect the cutaneous circulation, and thus bring about the desired result.—*Col. and Clin. Record.*

CORRESPONDENCE.

TAIT'S VERACITY.

EDITOR OF COLUMBUS MEDICAL JOURNAL.—Dear Doctor: Your letter of the 14th inst. received. You say that several medical journals are inclined to strongly intimate that Mr. Lawson Tait either selected his cases in his phenomenal run of 139, or else lies in his report, and you request me to give my views on the subject for publication in your Journal. This request will be most heartily complied with.

I was at Birmingham for the purpose of seeing Mr. Tait at work for many weeks. I saw every operation made by him while I was there, except one emergency case, which was operated upon in the afternoon when I was at work in another part of the city. This case recovered as well as every case of ovariectomy made by him during my stay there. I kept my own notes of the cases and followed them up, and I know there is no possibility of one death without my knowledge of it. As for his selecting only good cases for operation, the assertion is simply bosh. He operates upon every case, good or bad, old or young. I do not see how any man can accuse him of selecting cases if he knows anything at all of him and his teaching. He lays down the surgical law "*that in every case of disease in the abdomen or pelvis, in which the health is destroyed or life threatened, and in which the condition is not evidently due to malignant disease, an exploration of the cavity should be made.*"

I can say that he follows this law to the letter. He made a number of exploratory incisions while I was there, all of which recovered.

Yours truly, RUFUS B. HALL.

Chillicothe, Ohio, Oct. 16, 1886.

HOW TO DETECT A MORPHINE-TAKER.—Professor Bull, of Paris, states that there are two ways by which the morphine habitue can be detected, and these are to be found in the skin and in the urine. The skin will be found to be covered with little dark spots situated in the center of little indurations about the size of a large shot. It is needless to add that these indurations are the result of the little wound of the needle, but as these lesions are generally found on the inside of the thighs, the patient refuses to let them be seen, and in that case examination of the urine will prove of great service. A few drops of tincture of iron are put into the suspected liquid, and if morphia be present a blue tinge will be produced.—*Med. Record.*

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NATURES NERVE TONIC AND BRAIN FOOD.

Yielding the most remarkable results in both Functional and Organic Diseases of the Brain and Nerves, especially

NEURALGIA,	OPIUM and MORPHINE HABITS,	SPERMATORRHOEA
INSOMNIA,	INFANTILE PARALYSIS,	TIC DOLOREUX,
SCIATICA,	NERVOUS DYSPEPSIA,	MELANCHOLIA,
MANIA,	NEURASTHENIA,	IMPOTENCY.

FORMULA.—AVENA or Avenacea the active principle of the Oat (Avena Sativa), obtained by crushing the grain (dried in vacuo), with pure alcohol, skimming off the fatty scum obtained by ether, washing, evaporating to dryness, and then dissolving the amorphous powder (Avena) with boiling alcohol and flavoring. The dried grain is then treated to maceration and percolation from 96 to 144 hours. The final solution is of a 3½ per cent. strength.

NOTE. Most remarkable cures of the OPIUM HABIT. The most active tonic to both male and female SEXUAL ORGANS known. Almost specific in IMPOTENCY and SPERMATORRHOEA. As a Brain and Nerve Tonic and Restorer of Wasted Energy it is unparalleled.

Put up in 3 oz. bottles. Price, \$1. For sale in all drug stores.

SCOTCH OATS ESSENCE COMPANY, 174 Fulton Street, New York.

Heating and Ventilating.

The connection of the heating of a house with its ventilation is, of course, inseparable. Many persons will cheerfully expend ten or fifteen thousand dollars in building a house, putting from two to three thousand on outside ornaments, who would not dream of spending five hundred or one thousand dollars for the necessary Hot Water Apparatus to keep this same house thoroughly and comfortably warmed and well ventilated.

In reading the reports from the various Boards of Health, one can not fail to notice the startling increase in the death rate from Scarlet Fever, Diphtheria, and allied diseases. It might safely be said that this condition of affairs is due to the fact that the tightly closed doors and windows, which cold weather makes necessary, prevents the ventilation of houses, which is essential to the maintenance of health.

To those who intend erecting a dwelling, we would advise that the matter of heating and ventilating be given much consideration; and before deciding how it shall be done, consult the A. A. Griffing Iron Co., Manufacturers of the Tompkins Hot Water Indirect Radiator, 518 Communipaw Ave., Jersey City, N. J.

Fluid Forms of Hydrastis.

The reputation of this drug as a therapeutic agent was first gained through its employment in the form of an *infusion*; and in the fifty years following its introduction into medical practice, a continuous effort has been made by manufacturers to perfect a preparation which would represent all the active principles of the drug, without the high price of the salts, either alone or in combination.

The most prejudiced writers on *Materia Medica*, accord to the late Wm. S. Merrell the largest share of credit in the introduction of Hydrastis preparations, and to the present organization the reputation of being the *largest consumers of the drug in the world*. For more than a half-century, Hydrastis has been made a study in our laboratory, and we do not think we exaggerate its importance when we assert that it stands pre-eminent to-day as the most valuable exponent of our vegetable *Materia Medica*.

The following preparations *in fluid form* are receiving our special attention at this time:

Fluid Hydrastis—MERRELL.

Is what its name implies—the active, medicinal principles of the drug in natural combination and in a fluid form. It has a bright, yellow color, perfectly clear, free from sediment, and with an unmistakable odor of the *fresh drug*.

Fluid Hydrastis is a pure, neutral solution of all the alkaloidal constituents of the drug, rejecting the oil, gums, irritating and offensive resins and inert extractive matters. The success attending its introduction is the best evidence of its therapeutic value.

Unsuccessful imitations and would-be substitutes are met with on every hand. Preparations said to be “just as good” or “about the same thing,” but always “a little cheaper,” attest the wide-spread and growing popularity of Fluid Hydrastis. All such, compared with the latter as to physical appearance or as representatives of the drug, *are condemned*; dispensed in prescriptions, *they are readily detected*; tested therapeutically, they are *promptly rejected* as unworthy of confidence.

Fluid Hydrastis is applicable to the treatment of all irritable, inflammatory and ulcerative conditions of the mucous tract.

This statement of a well-known medical writer and journalist has become axiomatic:

“No remedy for physician's use has been received with such universal approval.”

Solution Bismuth and Hydrastia—MERRELL.

An invaluable and scientific combination, wherein the beneficial action of the white alkaloid is increased by association with Bismuth. This solution contains $2\frac{1}{2}$ grains of the double Citrate Bismuth and Hydrastia; twenty-five per cent. of which is Hydrastia Citrate.

The cordial reception accorded this preparation marks it as the most valuable combination in the market in which the white alkaloid alone represents the valuable properties of the drug. Used in diseases of the nasal passages, of the eye, of the throat, of the stomach and intestines, of the reproductive organs and bladder it is equally beneficial.

Colorless Solution of Hydrastia—MERRELL.

This is a permanent solution of the white alkaloid, without the addition of any other medicinal agent to modify or increase its action. It is offered without special recommendation to meet the views of an unlimited number of physicians, with whom the color of the Fluid Hydrastis is an objection. This solution contains in one fluid pint the same proportionate strength of white alkaloid as exists in an average quality of crude root.

See notes above on Solution Bismuth and Hydrastia.

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HANN & ADAIR, Publishers, Columbus, O.

THE ALLEGED INCREASE OF INSANITY.—In our last issue Dr. Wilson presented a valuable and interesting study of the statistics of the insane in Ohio. Similar studies have been made elsewhere, and have, we think, excited unnecessary apprehensions as to an increasing tendency to insanity among our people.

Most of this increase is apparent and not real, as has been shown by Dr. Andrews, of the Buffalo Asylum. Science and humanity have greatly extended the boundaries of insanity, so that many are now treated as insane who would a few years ago have been regarded as merely eccentric. A few years ago it was only the actively maniacal or the helplessly demented that were admitted to asylums or placed in jails and poor-houses; now almost every form of neurotic disorder affecting the mental powers is deemed a proper matter for treatment. Again, the census reports, previous to that of 1880, are too uncertain and poorly constructed to be of more than relative value; they cannot properly be used in comparison with that of 1880. For instance, the census of 1870 gave the total insane of Illinois as 1,621; while the State Board of Charities placed the number at 2,376. That the insane population of the United States, from 1870 to 1880, increased five times as fast as the general population, is incredible. We must look elsewhere than to these census returns for safe comparisons.

The greater *longevity* of the insane is another important factor in producing the numerical increase. Better treatment, medicinal and hygienic, and better surroundings have added many years to the lives of the insane.

One of the most exhaustive studies of this subject which we have seen was reported to the American Public Health Association in 1883, by Dr. Foster Pratt, of Michigan. He shows conclusively that it is to our foreign-born population, and their immediate descendants, that we are indebted for our increased insane population. The foreign-born, in 1850, were one-tenth of the population and furnished one-seventh of the insane; in 1860, were one-eighth of the population, and furnished one-fourth of the insane; in 1870, and also in 1880, were one-seventh of the population, and furnished nearly one-third of the insane. In other words, the foreign-born, from 1850 to 1860, had increased nearly one hundred per cent., their insane 181 per cent.; from 1860 to 1870, the foreign increase was thirty per cent., their insane nearly one hundred per cent.; from 1870 to 1880, the foreign increase was less than twenty per cent., their insane 150 per cent. Or, for further illustration, of native population, in 1860, there was one insane in 1,545; in 1860, one 1,559; in 1870, one in 1,258; in 1880 (a more careful census), one in 662; while of foreign-born population, in 1850, there was one insane in 1,095; in 1860, one in 717; in 1870, one in 497; in 1880, one in 250. While in 1850 the proportion of insane among the foreign-born was nearly the same as among the native-born, each succeeding census has revealed a rapidly increasing proportion of the foreign insane. Dr. Pratt's charge that other governments have been quietly unloading their defective class upon us, by "assisting" emigrants, is not capable of successful denial.

In direct connection with this subject of foreign population, must be considered that of their *descendants*. In 1880 there were 1,811,098 persons in this country the children of the intermarriage of native and foreign-born parents, and 13,011,646 whose parents were *both foreign-born*; total, 21,494,074, or nearly one-half the entire white population. We know of no figures which show the proportion of insane among this class of "native-born," but it must inevitably be large.

That there is, in modern times, an increasing number of persons becoming affected with insanity, or other nervous diseases, who would not have become thus affected fifty years ago, is true. As Dr. Pratt puts it: "We see more, hear more, read more, think more, feel more, know more, do more and worry more in ten years than our grandfathers did in thirty. Where does the strain of this intensity fall? Not on our physical strength; for we do not labor as hard, physically, as did our fathers before us. The strain of intensified life falls, and of a necessity must fall, on the brain and nervous system." But, on the other hand, these influences

are nearly or quite counterbalanced by those exerted by the better food and clothing of the laborers of to-day, by the better care taken of our indigent poor, and by the better hygiene that pervades the living of all classes, as contrasted with the conditions of fifty years ago.

To determine whether or not there is an increasing tendency to insanity, only the new cases must be considered, and these should certainly be classified as to birth and parentage. We know of no statistics in this country that can be thus used. In England such records have been kept since 1878, and they show, says D. Hack Tuke, "very little variation indeed in the occurrence of mental disorders * * * ; in fact, there is a slight tendency to diminution." Dr. Clouston's figures, he says, accord with those of Dr. Tuke, as do also those of Dr. Cobbold and the Commissioners of Lunacy of Great Britain.

Taking all things into consideration, then, we are inclined to think that there is no cause whatever for alarm over the apparent increase in our insane population. That our State and National Governments should take steps to protect us against "assisted" emigrants, is self-evident. If this influx can be stopped, the natural growth and development of our people will soon bring the proportion of the insane to the sane to what we must accept as about natural. The insane, like the poor, we must expect to have always with us.

STINKAPATHISTS, THEIR FAITH AND PRACTICE.—Classification is a great thing. To arrange in a convenient manner the separate items of our knowledge on any subject, calls for our best analytical and synthetical powers. Aside from dermatology, the proper classification of doctors most perplexes the medical profession and the laity. True, we may divide into two classes—regular and irregular—the entire mass; but here again there is a difference of opinion as to the characteristics of either. With each individual doctor he is regular who follows the speaker's belief and practice. But our object is not to discuss this subject, only to direct attention to a description of one class of doctors, as given by Dr. Raymond in the *Miss. Valley Medical Monthly*, Feb. 10, 1886. Concerning the "stinkapathists," he says it makes no difference when or where they graduated, or whether they had graduated at all, they all practice in the same general way, and their confession of faith and practice is about thus :

1. When a physician has located in a place he should advertise himself in every conceivable way; let him practice a year free for some blatherskite newspaper editor to get him to blow for him. He should sign his name with F. R. S., M. D.

2. A physician should never, under any circumstances, or for any consideration, allow himself to speak favorably of any other doctor, and if some one else does so in his presence, offset the remark as far as possible by one of his own.

3. If a neighboring physician happens to lose a couple of cases of diphtheria, it is the bounden duty of any struggling stinkapathist to remark in the right place, in a casual way, that he is sorry for Dr. Blank's misfortune, and then add, that since adopting the new treatment, he hasn't lost a case from the disease.

4. If a physician is called accidentally, or through the courtesy of another doctor, to consult in a case of simple remittent fever, he should examine the case a long time, and ask about eleven hundred questions which he knows from the nature of the case, and the good sense of the physician in charge, have not been asked, and when he has ascertained what the treatment has been, it shall be his duty to suggest a change, at any rate. If the physician in charge is giving sulphate of quinine, suggest the bromide or valerianate; and he should always make it a point to have these things somewhere about his old clothes, as the patient might recover entirely before the prescription could be sent for.

5. When a physician is called to consult in a case of puerperal fever, for instance, and the patient is not likely to recover under any plan of treatment, and the consulting doctor fails to get an invitation to treat the patient farther in connection with the physician in charge, he should go about town and tell everybody he can that the patient is not dangerously ill at all, and will be up in a few days if properly handled.

6. If a physician is called to consult in a case of cerebro-spinal meningitis, and the patient is in *articulo mortis* when he arrives, he should not examine at all, but take in the situation at a glance, remembering that his opportunity for "turning a Jack" in the case will not last long enough to find out what he hasn't done. Then it shall be his duty to pull off his coat, push up his sleeves and go to work. He must order water heated, and a tub full of cold from the well or cistern, put some bricks in the fire, go into his saddle bags, if he be a country physician, and get out something and give it to the patient, get out his hypodermic syringe, but don't use it, give the patient half a pound of epsom salts if he can swallow. Send a fellow five miles for a big old-fashioned syringe, and another for some whisky, and by this time the patient is in paradise. The physician shall then make sure of death, slowly gather up his instruments and things, and sorrowfully bid his audience adieu, and tell some one he may meet as he goes away that he was too late.

When you find a doctor who adheres religiously to such rules, you have a genuine uncomplicated case of cussedness that is past the art of man to cure, no matter where he hails from, to what school he belongs, how large his practice, or what hold he may have upon the hearts and pockets of the laity. And to talk to him about being honorable is like singing psalms to a deceased horse.—*Am. Lancet*.

THE death of Joseph Samson Gamgee, the celebrated English surgeon, occurred September 18. He had chronic Bright's disease, but the more immediate cause of death was a fracture of the neck of the thigh bone. His age was fifty-nine.

REVIEWS AND BOOK NOTICES.

BIBLIOGRAPHICAL NOTE.—The following Extracts from the Preface to the just issued (sixth) edition of the Principles and Practice of Medicine by the late Dr. Austin Flint will be read with interest, as evincing alike the enormous personal experience upon which the author founded his opinions and the very complete manner in which he has presented to the fellow-members of his profession the matured results of his life's labors.

"The basis of the work is an unbroken series of records of cases in private practice and in hospitals, begun in 1833 and continued for more than half a century, covering sixteen thousand nine hundred and twenty-two folio pages of manuscript, written with the author's own hand. These records embrace carefully written histories of cases in all departments of practical medicine, observed under varied conditions of life, climate, and general surroundings. Soldiers in camp and barracks; the rich and poor; those affected with diseases incident to lives of ease and luxury, and paupers in hospitals; the pioneers of Western New York, and the inhabitants of the metropolis; patients in the wards of the almshouse and hospitals of Buffalo, of the Marine Hospital in Louisville, Kentucky, the great Charity Hospital in New Orleans, Louisiana, the Bellevue Hospital, the Charity Hospital, the dispensaries, and similar institutions in the city of New York; cases observed in the experience of a quarter of a century as a general practitioner, and of more than another quarter of a century as a consulting physician, including the epidemics which have occurred in this country within the last fifty years—the experience derived from these various sources of observation, carefully recorded, studied and analyzed, was finally used in the composition of this treatise, the first edition of which appeared in 1866. In the meantime, the author's original contributions to practical medicine, embodied in special treatises, in communications published in medical periodicals, and in Transactions of medical societies, have left their impress upon many departments which, in recent years, have been classed as specialties; although he was always a physician, never a specialist. A student of the history of practical medicine will often find observations and ideas, assumed to be of recent date, which had been anticipated by the author many years before.

"The claim in the Preface to the fifth edition, "that the eliminations, substitutions, and additions rendered it essentially a new work," can with equal propriety be made for the present edition as compared with the edition issued in 1881. Among the entirely new articles, special attention may be called to the following: Infectious Tumors; Syphilitic Diseases of the Lungs; Cerebral Syphilis; General Considerations relating to Inflammatory and Structural Diseases of the Spinal Cord; Spastic Cerebral Paralysis of Children; Hereditary Ataxia; Myxedema; Multiple Neuritis; General Pathology of Fever; and Milk Sickness. In addition to these new features, many articles have been entirely re-written; and in

nearly every article changes and additions, some of them very important, have been made.

"As already stated, the sixth edition contains a full consideration of recent discoveries concerning the bacterial origin of various infectious diseases, as will be rendered evident by a consultation of the article on Vegetable Parasites in the chapter on Etiology, and articles in the chapters treating of Tuberculosis, Typhoid Fever, Cholera, etc."

A Reference Hand-Book of the Medical Sciences. Embracing the entire range of Scientific and Practical Medicine and Allied Science, by various writers. Vol. III, FAC to HYS. 813 pages. Illustrated by six chromo-lithographs and 718 fine wood engravings. Edited by Albert H. Buck, M. D. Supplied to subscribers only. Price per vol., cloth, \$6.00; sheep, \$7.00; half morocco, \$8.00. William Wood & Co., New York.

Among the leading articles in this volume—which contains from Face to Hysterotomy—are several which may receive special notice.

The first article is an excellent one, being illustrated with cuts showing the characteristics of the Indo-Germanic races, the Mongolians, the Eskimos, Lapps and Finns, and the North and South African races, and one showing the gradual retreat of the jaws in passing from lower to higher types of face. Following this is the embryological development of the face, and the significance of facial expression.

The article on typhoid fever is embellished with a particularly fine chromo-lithograph showing the lesions of that disease.

Dr. Geo. E. Sternberg contributes the article on typho-malarial fever, which he regards not as a distinct fever, but as simply a clinical variety of typhoid.

Gangrene, by Surgeon-General Hamilton, is also illustrated by several chromo-lithographs.

The article on Field Surgeons, though of no immediate value just now, is very thorough, dealing with all the exigencies of war, both on land and sea. It is well supplemented by the articles on Hospitals and Hygiene.

The Hand, Heart, Hemorrhoids, Hernia and Histology have each especially attractive and well illustrated articles. Indeed, a feature of the entire work is its richness of illustrations.

We cannot regard this volume as either more or less valuable than its predecessors; they all constitute an exceedingly valuable and complete library.

The Physician's Leisure Library.—This is a series of twelve new and valuable medical books, by eminent authors, issued by the publish-

ing house of Geo. S. Davis, Detroit, Mich. Of this library the publishers have issued the following, viz: "New Medication," two volumes, by Dujardin Beaumetz, M.D., translated by E. P. Hurd, M. D.; "Inhalers, Inhalations and Inhalants," by Beverly Robinson, M. D.; "The Modern Treatment of Ear Diseases," by Samuel Sexton, M.D.; "The Use of Electricity in the Removal of Superfluous Hair, and in the Treatment of Various Facial Blemishes," by Geo. Henry Fox, M. D.; and "Spinal Irritation," by William A. Hammond, M.D.

The twelve books complete are sold for \$2.50; 25c each. They are printed on good paper with heavy paper covers.

This series will afford physicians and students an opportunity of purchasing many of the most valuable works at a price within the reach of all; for we understand that only first-class monographs will be published. We will notice the succeeding volumes as they reach us. Address, Geo. S. Davis, publisher, Detroit, Mich.

Surgical Diseases of the Kidneys. By Henry Morris, M. A., M. B., F. R. C. S., Surgeon to and Lecturer on Surgery at the Middlesex Hospital, London. 12mo., 555 pages, with 6 chromo-lithographic plates and 40 engravings. Cloth, \$2.25. Philadelphia, Lea Bro's & Co., 1886.

Although of comparatively small dimensions, this book very completely covers the field of investigation. It contains a brief description of the normal and regional anatomy; a very full account of malformations and abnormal anatomical relations of the kidney, matters of importance to the surgeon who is about to operate on the organ; also, descriptions of the injuries and diseases of the kidney, and of the methods of performing nephrectomy, nephro-lithotomy, nephrotomy, aspiratory puncture, and nephrorraphy. It also includes descriptions of those affections of the kidney which are secondary to obstruction in, or operations upon, the lower urinary organs; such as suppurative nephritis, hydronephrosis, pyonephrosis, and urinary fever.

A Treatise on Electrolysis, and Its Application to Therapeutical and Surgical Treatment in Diseases. By Robert Amory, A. M., M. D., (Harv.) Fellow Mass. Med. Society; American Academy of Medicine; formerly Professor of Physiology Bowdoin Med. College, etc., New York. William Wood & Co., 1886.

The author gives a hundred pages of elementary matter to a statement of the principles of physics as applicable to electrolysis. He thus presents the natural laws which affect the construction and destruction of living tissues, so that a practitioner may meet the conditions of

diseased tissues in a rational way, and know when not to resort to electrolysis in cases not amenable to its action.

The book includes only the special field of electrolysis. After a general description of the methods of electrolytic application it gives forty-six pages to electrolysis of exophthalmic goitre, and sixteen pages to hypertrichosis. It includes, also, the treatment of cancer, angioma, aneurism, varices, ovarian tumors, hydrocele, orchitis, urethral stricture, etc., etc.

Analysis of the Urine, with Special Reference to the Diseases of the Genito-Urinary Organs. By H. B. Hofmann, Professor in the University of Gratz, and R. Ultzmann, Docent in the University of Vienna. Translated by T. Burton Brune, A.M., M.D., and H. Holbrook Curtis, Ph.B., M.D. Second edition. 8vo., 305 pages. Illustrated. Price, \$2.00. New York: D. Appleton & Co., 1886. Columbus; Geo. H. Twiss.

Professors Hofmann and Ultzmann here give us a clear, correct, and concise guide in urinalysis and in the diagnosis of disease of the genito-urinary organs. The translators, in addition to their excellent work as such, incorporated in the book much that has recently been added to our knowledge on the subject.

The authors, in their preface, say that they have eliminated all unnecessary matter, and have endeavored to make the processes so simple that but a limited knowledge of chemistry will be necessary to understand tests. We commend this work as one of value and interest to the profession. The type is large and clear, the paper and binding excellent, and the illustrations instructive.

Index Catalogue of the Library of the Surgeon-General's Office, United States Army. Vol. VII.

The seventh of this series of volumes has made its appearance, and brings the alphabetically arranged mass of material which the entire set is to produce down to, "Leghorn." Sixty pages of fine print are necessary to give the references under "Intestine," forty under "Jaw," thirty under "Knee-joint," twenty-five under "Jurisprudence," forty-five under "Kidney," and fifty under "Labor." This gives an idea of the work and the mass of material presented for reference.

Reed & Carnrick's Diet Tables.—This is a very handy little pocket-book, issued by Messrs. Reed & Carnrick, giving diet lists suitable for cases of Bright's disease, chlorosis, cholera infantum, chronic rheumatism, constipation, diabetes, diarrhea, dyspepsia, fever, gout, nervous affections, obesity and phthisis; also a general list for the sick and one specially suited to infants. The arrangement is simple, and the lists seem judiciously made up. For hasty reference, or to give to patients, the little book will doubtless prove very serviceable.

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COMMUNICATIONS.

SPRAINED JOINTS.

BY EDMUND OWEN, F. R. C. S., LONDON, ENG.

Surgeon to St. Mary's and the Children's Hospital.

A sprain is the result of a twist or wrench which has stretched the fibrous capsule of an articulation and its synovial membrane, but which has not sufficed to cause either fracture or dislocation. The injury should be treated upon exactly the same surgical principles as those which guide us in dealing with a fracture or dislocation of a joint; yet a joint which is "only sprained" is somewhat apt to obtain but scant professional attention. Though the common saying teaches that "A sprain is worse than a break," the unfortunate subject of a sprain is usually contented with doing the best that he can for himself with arnica, cold water, or oil, as chance, experience, or advice may suggest, seeking the surgeon's aid only for the remote and often intractable complications. In unhealthy subjects, and, especially in children, want of treatment often entails articular troubles which run a lingering course and may end disastrously; and even with the strong a severe sprain is apt to involve a long-continued enfeeblement of the part.

Immediately after the sprain there is want of pliability in the joint; due in part to the pain and tenderness caused by the violence, in part to

the tension of the sensory nerve filaments from the sudden effusion, and in part also to the mere mechanical effect of the presence of blood and other fluids in and around the joint. In certain situations a serious wrench of an articulation may give no visible sign upon the surface of the body ; especially is this the case with the hip, the shoulder, and the spinal articulations, all of which are thickly covered ; stiffness will then be the only objective sign indicative of the lesion.

If a joint in the lower extremity be seriously sprained, temporary but absolute rest for it should be insured by, if practicable, putting the patient at once to bed ; by raising the limb on a pillow, or in a swing cradle, until the heel is above the level of the chin, so as to hinder capillary and venous congestion ; and by applying firm and even compression. I am convinced that judiciously applied compression not only checks further effusion, but also promotes the absorption of fluid which has been already poured out ; and, as a rule, the patient experiences immediate comfort from it. At times, however, it is possible that from the tenderness of the skin, or from mere apprehension, the patient will not submit to the compression immediately after the injury. Then one must be content to apply either the ice-bag or an evaporating lotion. Cold plays a double part : by stimulating the vaso-motor nerves it causes a contraction of the small arteries, with the effect of checking further hemorrhage and inflammation and limiting the effusion, and by numbing the sensory nerves it diminishes pain. The lotion should not be used, however, as is often done, as a water-dressing under oil-silk. It must be applied on a single fold of lint with the fluffy side outwards, so that evaporation may proceed with energy. The lint must never be allowed to get dry, nor should the limb be covered over with bed-clothes. If a man sprains his ankle when out in the fields it should as quickly as possible be put into running water, and then be firmly bandaged with strips of wetted handkerchiefs ; the boot should be worn, if he can get it on again, for the sake of the compression it affords, but it is better not to remove the boot at all until the joint can be bandaged. Nothing short of absolute rest in bed suffices when a child sprains a joint in the lower extremity ; he must not be trusted to lie on a sofa, for he would soon be off of it. Where the hip-joint is sprained the limb should be raised and rest insured in the extended position by the application of the weight and pulley ; so that if matters do not clear up there will be no need for further change of position. A sprain is often the beginning of an attack of hip joint disease.

In the case of the knee being sprained, the leg would be extended; in the case of the ankle being sprained, the foot would be put up at a right angle. But in each instance the limb should be carefully bandaged upwards before the compression is applied, or edema may follow; complete rest would be still further ensured by adjusting a splint to the side or back of the limb. Compression may be applied by means of a roller of domette, or by the additional aid of plastic splinting moulded on. With children a well-padded flexible metal splint is of great service, but a casing of plaster of Paris and house flannel answers even better.

I have at present two men under my care, each with a severely sprained ankle, the part being swollen and discolored, and the foot stiff and useless. The foot and leg have been immobilised in well-lined plaster of Paris casings, and thus the patients are quickly enabled to get out of bed and go about with crutches, without risk or discomfort. In neither of these men was a fracture to be detected.

When an ankle is greatly swollen from a recent injury, and signs of fracture are not evident, it is not advisable to conduct the examination for obtaining a knowledge of the exact nature of the injury in too inquisitive a manner. If the limb be treated on the principles enunciated above, it will be well either for a severe sprain, or for a fracture without displacement. Possibly the patient might be unsettled at not being definitely informed whether there be fracture or not, for the oft-repeated question of the patient or parent as the surgeon examines the part is, "Is the bone broken?" But I am speaking merely of the principle involved in the surgery.

Absolute rest is demanded as long as heat of the surface or intra-articular pains persist. As the pains subside, recourse must be had to frictions and rubbings and the use of stimulating liniments and cold douches. The rubbings should be executed always in the direction of the venous and lymphatic return, and may be combined with firm fingerings about the part, and with the rubbing-in of olive oil. When effusion persists in the painless joint, one may apply over the joint the even compression of a Martin's elastic roller for a certain length of time each day, the skin being duly protected by a soft covering. This is a highly satisfactory method of treatment in cases of chronic thickening and effusion. Leslie's soap-strapping, too, when evenly and liberally applied over a sprained joint, is an excellent therapeutic measure in the days following close upon the injury.

At other times, nothing seems to render such efficient aid as a wetted calico bandage. Compression in some form is needed.

On physiological grounds, the early treatment of a sprained joint by fomentation or poultices is inexpedient. The application of warmth produces a vascular fulness of the part, and a relaxed condition of tissues which are in need of being toned up and strengthened; though if synovial inflammation of an acute kind follow on the sprain, leeches and fomentations may not improbably be indicated later on. For the promotion of the absorption of the lingering products of effusion, an alternation of douchings under streams of hot and cold water gives valuable aid. In no stage of the pathological process associated with a sprain should arnica solution be applied. One has met with instances in which painful and serious cellulitis has followed its use, even when there had been no previous lesion of skin. How is it that arnica first obtained its reputation in the treatment of sprains, and how has that reputation managed to survive so long?

A surgeon was driving his wife in the country when the pony fell, and the occupants of the carriage were thrown out into the road. When I saw him a few hours after the accident he was wearing his right arm in a sling, the elbow being at an obtuse angle. He said that, in the fall, the right hand (in which he was holding the reins) and the arm were doubled and twisted underneath him, and that though he was sure no bone had been broken, he could neither bend nor straighten the elbow on account of the severe sprain which it had received. He said that on his way home, and certainly well within an hour of the fall, on placing his left hand under the damaged elbow he found a soft swelling which seemed pretty near as large as an egg; his wife could also feel through his coat sleeve. Having taken the limb out of the sleeve and removed some water-dressings, universal and extensive effusion in the articulation was evident; the distended synovial membrane was specially bulging about the head of the radius. The intra-articular pain was intense. There was no contusion of the skin, nor any definite ecchymosis; movement caused great distress. Beginning at the fingers we firmly bandaged the extremity with a roller of domette (which from its softness and elasticity adapts itself with delightful evenness and comfort), drawing the turns which surrounded the swollen joint itself more closely and firmly for the sake of compression. Then, having bent to the proper form of the arm a padded flexible iron splint, and carefully adjusted it, the elbow was packed round with cotton-wool, and having enclosed all in a second

and wider domette roller, and having got the patient to bed, we arranged the arm upon a pillow. The compression and security afforded by the roller and splint gave great satisfaction. On the second day we re-adjusted the splint and bandages, which had now become slack. Most of the tenderness and swelling had departed. Two days later, and at other intervals, we tightened up the bandage, finding always steady improvement. In ten days the splint was removed, and cautious use of the arm was allowed, but for the entire removal of the stiffness a course of shampooing from a professional rubber was resorted to. The effusion which had come on so quickly, within an hour of the injury, was evidently not inflammatory in its nature; probably it consisted of synovia, blood and serum.

The other occupant of the carriage had severely sprained her left ankle, which was painful, stiff, and full of sero-synovial effusion. There was no fracture. The swelling was confined within the limits of the synovial membrane; it did not extend up above the external malleolus in the manner so characteristic of Pott's fracture. The treatment adopted consisted in surrounding the ankle with an even layer of cotton-wool, and in bandaging from the metatarsus upwards with a soft roller, the turns of which were continued well up the calf of the leg. The foot thus firmly encased was raised upon a pillow. In a few days all the excess of synovial fluid had disappeared, but the firmly-applied bandage was still worn. In a week she began to use her foot, and was finding comfort in having it and the ankle rubbed with oil several times during the day. On the occasion of my first interview, the patient volunteered the important clinical statement—that after the accident her foot and ankle were fairly comfortable until her boot was removed. Probably if a bandage or plaster Paris casing could have been applied immediately after the accident, but little joint effusion or edema would have occurred. Certainly, compression of a recently-sprained joint gives results, both as regards expedition and thoroughness, with which those obtainable by the system of evaporating lotions can not be compared.

If the sprained joint be in the thumb or finger, much pain and want of pliancy may result. A small splint should be moulded on; firm compression with a pad of cotton-wool and a soft bandage exercised; and the hand worn in a sling—it should not be left free except for the cold douchings. A few days absolute rest is expedient.

Even long years after all the local signs of a sprain have passed away, a jerked or sudden movement of the joint, or a change in the weather,

reminds the subject that the part is not absolutely sound. Nearly twenty years ago, I severely sprained my left wrist at football, and to this day it has not absolutely recovered. I cannot flex or extend it as I can its fellow. A sudden movement of it is often accompanied with audible crackling and discomfort. From a close and interested observation of this joint I feel convinced that in the crevices between the articular surfaces of the bones, and against the attached parts of the capsule out of the way of pressure, there are growing delicate and injected fringes of the synovial membrane. The synovial fluid is thin in quality and in excess of the normal amount; there are no adhesions inside the articulation, but there is probably some shortening of the extra-articular fibrous tissues which were implicated in the inflammation—a shortening secondary to inflammatory thickening. Probably this shortening of the fibrous tissues plays the important *role* of a perpetual splint shielding the enfeebled synovial membrane from further shock and distress. On no account, therefore, will these adhesions be broken down or stretched by manipulation: such a treatment is contra-indicated by the pain which closely attends any attempt at more than the accustomed movements of the joint. The very audible crackling, which even a bystander may sometimes hear on working the joint, is the result of the altered synovial fluid being quickly driven by the movements of the joint between the vascular fringes.

Occasionally when a joint has been wrenched by a recent accident, and is in consequence painful and useless, the manipulative examination which it receives from the surgeon is the means of removing much of the pain, as well as restoring a good deal of the lost function. I am satisfied that such improvement is real, and not merely subjective. Yet because in the weakly and ailing such a therapeutic measure might probably be attended either immediately or remotely by disastrous results, and because of its utterly speculative nature, it is not to be recommended as routine practice, though it may well be kept in reserve for rare and special occasions. It certainly has a close and important bearing upon bone-setting. A man sprains his ankle; the surgeon examines and reports accordingly; but, because no bone is broken, he perhaps speaks of the lesion in a careless or off-handed manner, and does not insist on the necessity of rest and of other appropriate treatment. So the ankle does not get sound, and the faithless patient resorts to a quack, who at once finds "a small bone out of place." Then come a sudden twist and a crack, and lo! "the bone is in again." The patient believes that a bone has there and then been restored to its place because he is at once absolutely more comforta-

ble, and can not only move the joint freely, but can even accept the advice to throw away his crutch or his stick, and walk on his damaged foot without further help. Perhaps he is told to go home and apply ice; at any rate from that time he considers himself to be—and indeed is—cured. Forcible manipulation is, of course, the bone-setter's panacea. I have known him to employ it in the case of fracture of the surgical neck of the humerus, and, as may be expected, with very serious results. In the case of recent sprain, however, the patient cannot but believe that the bone-setter's statement is true, because, beyond a doubt, his manipulation has proved effectual.

The following report illustrates the point:—A gentleman of highly nervous temperament came to me with considerable bruising of the deltoid, the day after receiving a fall which might have been attended with much more serious consequences. The arm was so stiff at the shoulder-joint that he could not raise it to dress himself, nor could he touch the ear of the opposite side whilst his elbow was brought toward the front of the chest,—it remained permanently though slightly abducted. Any movement of the arm was attended with pain and distress. There was no definite hollow beneath the acromion process, nor any other unequivocal sign of dislocation. There was a great element of obscurity in the case; the patient was in pain and apprehension, and expressed his fear that the shoulder-bone was “out.” A consultation on the case was not attainable, and the course of action had to be decided. So, to err upon the safe side—if error there might be—and in order to make a thorough and practical examination of the joint, I agreed with him that there was “displacement of the shoulder-bone,” and laying him upon the floor, with my heel in the axilla, I flexed the fore-arm to slacken the biceps, rotated and pulled down the arm, and then adducted it *vi et arte* and in a most determined manner. There was no click, or the sign of a re-adjustment having taken place, but immediately on the patient rising from the ground he said that he was much more comfortable; he had lost most of the pain; he could move his arm with comparative freedom; and to his delight and my satisfaction he dressed himself without assistance. He was convinced that I had reduced a dislocation. In my own mind I was sure that I had not, but for obvious reasons I did not tell him that the success attending my treatment was worthy of a more exact diagnosis. It is with no sense of pride that I record the case; nevertheless, it might be expedient to adopt this treatment on another similar occasion. With a hyper-sensitive and nervous patient, and a fat or swollen shoulder, it is

occasionally impossible to affirm without the aid of an anæsthetic that there is no displacement. Traction on the bent elbow with the heel in axilla enables the surgeon to make the necessary examination. Certain am I of this,—that my nervous patient would not have allowed me thoroughly to have examined him if I had first said that I thought there was no displacement.

I have observed the same course of events in other cases. For instance, a man has just damaged his ankle, which is now painful, swelled, and stiff; a thorough manipulative examination reveals no definite lesion. But immediately after the handling the patient finds the foot so much better in every respect that he talks too lightly of his injury and wishes at once to walk about. Or an elbow, knee, or wrist, is stiffened by a recent wrench. On being thoroughly overhauled, nothing is found absolutely wrong with it; but the patient, though a sufferer during the examination, finds the joint greatly improved by it. The surgeon will rightly refuse to include such a speculative therapeutic measure in his routine practice; but its blind employment by the charlatan is the means of securing many a triumphant success.

Where a limb is stiff from chronic muscular rheumatism much good may often be done by *massage* and by sudden movements imparted to it, the stiffness disappearing by magic, whilst no harm can follow the treatment.

Stiffness may follow on a sprain from effusion taking place, not into the synovial membrane of the articulation, but into a sheath in connexion with a neighboring tendon. One has often to treat such effusion in the sheaths of the extensors of the thumb and wrist, and also in those of the tendons of the tibial muscles and of the extensors of the toes. It is, of course, easy to differentiate between an articular and a thenar effusion; the same principles direct the treatment in each case. I have at the present time under my care a wrist which is stiffened from slight effusion into the sheath of the radial extensors; great relief is being afforded by the firm compression of a domette roller which is kept constantly wet.—*The Practitioner*.

In hemorrhoidal tumors five drops of a ten per cent. solution of phenic acid injected into the swelled veins almost immediately withers it up. Dr. Meniere employs the following formula, which he esteems superior to the simple solution, as the pain, which is often severe, is greatly lessened: glycerine, two drachms and a half; phenic acid, twenty drops; morphia, five grains.

THREE CASES OF FECAL ACCUMULATION.

BY J. W. HAMER, M. D., JOHNSTOWN, PA.

While reading the October issue of the Medical Bulletin, I noticed the report of Dr. J. E. Hoffman, given of a case of paresis of the bowels. It brought to my recollection the experience I had in three similar cases, except the paretic condition. The accumulation in Dr. Hoffman's case was due to paresis of the bowels. In my cases the accumulation was not due to any paretic condition of the bowels, for the simple reason that the bowels moved regularly before and after the removal of the accumulation, and needed no medicines to restore functional activity, neither was there any need of applying electricity, as the case of Dr. Hoffman.

On May 13, 1882, I was called to see Mr. C., aged 50. I found him suffering from a severe pain in the right iliac region. He had been treated for nearly a week by another physician for an abscess. He had been blistered, and poulticed with nearly everything imaginable, the pains becoming more severe every day; in fact were unbearable unless he was under the influence of large doses of morphia. Not seeing any prospects of benefit, the patient concluded to change doctors. On inspection I noticed the "abscess" but on palpating and close examination of the enlargement I diagnosed, very satisfactorily to myself at least, impaction of fecal matter in the ascending colon.

I ordered a large dose of sulphate of magnesia, to be followed by large draughts of water. I visited him again in the evening, about six hours after the morning visit, and about three hours after the action of the cathartic. I found him resting very much easier than in the morning and the "abscess" greatly reduced in size and tenderness, but still found some impaction, but thought it would break down and pass off without the use of any more medicine. I visited him again the next morning and still found that the accumulation had not entirely disappeared. I ordered another dose of sulphate of magnesia, to be followed by draughts of water. At my fourth and last visit I found to my satisfaction, and to the satisfaction of my patient as well, that the fecal accumulation had entirely broken down and passed off. The patient was very much weakened by the treatment, but in a few days was himself again.

2d. Case. I was called to see my second case October 10, 1882, a lad aged fourteen. The parents thought he was suffering from a tumor

growing in his side. A close examination was made, and I soon made up my mind that it was an impaction of fecal matter. The parents doubted my diagnosis, as the lad was suffering from a diarrhea at the time. I explained to them that it is possible to have diarrhea and still the walls of the intestines to heave accumulations of fecal matter adhering to them. They finally yielded and submitted to my treatment which was the same as in my first case, and with the same good result.

My third case happened June 2, 1884. An aged lady was suffering from what she thought was piles. On examination per rectum I found a large amount of fecal accumulation extending to the sigmoidal. In this case I preceded the sulphate of magensia by three grs. of aloes and six hours afterwards gave the magnesia, as in the first and second cases. On account of her age, and the debility brought on by her suffering, tonics were given her to restore appetite &c.

WIT AND WISDOM.—The late Dr. Moxon had a mind which habitually saw the humerous side of all things; every event and every statement seemed to be present to his mind in two aspects, and many of his sayings would be well worth preserving. His descriptions of some of the aspects of the teetotal movement as "intemperate abstinence," and his definition of syphilis as "a fever diluted with time," are instances in point. As a teacher of materia medica, the shafts of his satire were frequently directed against inert drugs and obsolete formula; of elm-bark for instance, he vouchsafed no further information than that the wood was "good for making coffins." His grave discussion of the motto of Guy's Hospital, "*Dare quam accipere*," whether it had not reference to the stock mixtures, not only raised laughter at the time, but served a useful purpose by drawing attention to the fact that some of these old-fashioned remedies were horribly nauseous, and probably not very active.

EFFICIENT SEDATIVE COUGH MIXTURE.—When Dr. H. C. Wood recommends anything, it is a guarantee of its merit. Hence we take the following from the *Therapeutic Gazette*:

R.	Potassi citratis,	ʒj.
	Succi limonis,	ʒij.
	Syr. ipecac,	ʒss.
	Syr. simplicis, q. s.	ad. ʒvj.

M. Sig.—A tablespoonful from four to six times a day.

When there is much cough or irritability of the bowels, paregoric may be added.

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HORSFORD'S ACID PHOSPHATE,

versus

Dilute Phosphoric Acid.

The attention of the profession is respectfully invited to some points of difference between Horsford's Acid Phosphate and the dilute phosphoric acid of the pharmacopeia. Horsford's Acid Phosphate is a solution of the phosphates of lime, magnesia, potash, and iron in such form as to be readily assimilated by the system, and containing no pyro- or meta-phosphate of any base whatever. It is not made by compounding phosphoric acid, lime, potash, etc., in the laboratory, but is obtained in the form in which it exists in the animal system. Dilute phosphoric acid is simply phosphoric acid and water without any base. Experience has shown that while in certain cases dilute phosphoric acid interfered with digestion, Horsford's Acid Phosphate not only caused no trouble with the digestive organs, but promoted in a marked degree their healthful action. Practice has shown in a great variety of cases that it is a phosphate with an excess of phosphoric acid that will better meet the requirements of the system than either phosphoric acid or a simple phosphate. "Phosphorus," as such, is not found in the human body, but phosphoric acid in combination with lime, iron and other bases, *i. e.* the phosphates, is found in the bones, blood, brain and muscle. It is the phosphates and not the simple phosphoric acid that is found in the urine after severe mental and physical exertions, or during wasting diseases.

We have received a very large number of letters from physicians of the highest standing, in all parts of the country, relating their experience with the Acid Phosphate, and speaking of it in high terms of commendation.

Physicians who have not used Horsford's Acid Phosphate, and who wish to test it, will be furnished a sample on application, without expense, except express charges.

RUMFORD CHEMICAL WORKS,

Providence, R. I.

 BEWARE OF IMITATIONS.

OBSTETRICS.

INCOMPLETE ABORTION; MANAGEMENT OF.—(Dr. A. W. Edis, in the *Brit. Med. Jour.*)—The subject of incomplete abortion, or imperfect expulsion of the whole of the ovum, cannot fail to prove of interest to all who have to deal with the emergencies of general practice. The risk to the patient, whether from primary hemorrhage or from septicemia, is often very great; a fatal issue is by no means infrequent, and even where this does not result, the general health may become seriously affected from the prolonged hemorrhage, septic absorption, or uterine disorder ensuing in consequence.

The consequences of incomplete abortion are far more serious than at first might be imagined. Many a young life has been prematurely cut short, the hopes of maternity blighted, or prolonged uterine trouble induced, in consequence of an early miscarriage, within a few months of the commencement of married life, not having been properly managed.

It will be beyond the scope of the present communication to allude even to the causation, symptoms, diagnosis, prophylaxis, or treatment of abortion generally. My remarks will be confined solely to the management of incomplete abortion, where the ovisac has ruptured, the embryo been expelled only in part—the placenta, either entire or in fragments, being retained in utero, and giving rise to hemorrhage or septicemia in consequence.

The principle of early and complete evacuation of the contents of the uterus, where the vitality of the ovum has been destroyed, and abortion is inevitable, although generally accepted by everyone competent to give an opinion, is yet too often neglected in actual practice, and leads to the most calamitous results. The following cases will illustrate this:

M. T., aged 27, single. When first seen in consultation with her medical man, who had only been called in a few days previously, I found her lying in bed, on her back, with the knees drawn up, the abdomen tympanitic, very tender on the least pressure. The pulse was 144, very feeble; temperature 103.2° Fahr. The tongue was thickly coated, red at the edges, and inclined to be dry. She was delirious at times, but could be roused to answer questions. There was persistent fetid diarrhea, constant sickness, and much pain complained of all over the abdomen. On vaginal examination, a sanious sanguineous discharge was found

exuding from the os uteri, which was somewhat patulous. The uterus was enlarged, fairly mobile, retroverted. Thus far, no history had been obtained explaining her symptoms. Seeing that the patient was in a most critical condition, evidently suffering from septic peritonitis, I elicited from her paramour that she had had a miscarriage, procured some days previously by a midwife. She had missed two periods, and came up to town for the purpose of being set right. Two days afterwards, she had severe pain and profuse hemorrhage, but I could get no well-marked history of any substance having passed. She became very feverish, and was compelled to keep in bed. It was not until nearly a week after this that a medical man was called in, and then he was told nothing beyond that she was losing blood.

The patient was too ill to bear much interference. The uterine cavity was thoroughly irrigated with iodized water, quinine and opium administered, and every effort made to rally the patient; but she sank and died within twelve hours of my seeing her.

There can be no question that retained products of conception, decomposing within the uterus, had given life to septic peritonitis. Had these been removed, and the case properly treated from the outset, the issue would, in all probability, have been different. One can but regret that skilled assistance had not been rendered until the patient's condition precluded any active treatment from being adopted.

In nulliparæ, where, after cessation of the catamenia for one or more periods, and the ordinary signs and symptoms of pregnancy exist, pain and hemorrhage occur, showing abortion to be inevitable, our object should be to favor the expulsion of the ovum with as little delay as possible. The insertion of a carbolized sponge-tent into the cervix uteri, for a few hours, will not only serve to check the hemorrhage, if this be at all profuse, but also to dilate the cervix, and to facilitate the expulsion of the ovum entire. It is in these cases, owing to the undeveloped or undilatable condition of the cervix, more especially where ergot has been too freely administered, that the ovisac becomes ruptured, the embryo expelled, and chorionic villi or placenta retained.

Mere plugging the vagina with the intention of arresting hemorrhage from the uterus is both unscientific as well as unsatisfactory, and should never be resorted to unless in severe emergencies, where either the practitioner has not the instruments at hand, or does not possess the requisite manipulative skill for passing a sponge-tent into the cervix uteri.

In such cases, small pieces of sponge wrung out of iodized or carbolyzed water, or other antiseptic solution, are preferable to the ordinary cotton wool or strips of linen usually employed, in that the former tend to expand, and fill up the vagina when moistened, whereas the latter shrink, and allow the hemorrhage to continue. A vaginal tampon, in any case, should never be left in for more than a few hours without being removed.

In the event of a sponge-tent having been inserted into the cervix uteri, and the hemorrhage arrested for the time being, the question will arise, How long shall this be left in before making efforts to empty the uterus? This will depend somewhat upon the time of the day or night when the practitioner has passed the tent, the amount of hemorrhage which has already occurred, and other considerations. Owing to the extreme nervousness of the patient, her intolerance of any digital interference, the limited capacity of the vagina, or inability to depress the uterus, by conjoined manipulation, owing to the patient holding herself so rigidly, the administration of an anesthetic will generally be found requisite. This should invariably be entrusted to some competent assistant, and not left to the discretion of some unqualified friend or nurse. The operator is thus free to direct his attention solely to the evacuation of the uterus, which must be done systematically and thoroughly, not partially and imperfectly, as this increases the risk of hemorrhage and septicemia. The time selected, therefore, may be regulated somewhat by the practitioner's convenience; if the tent be inserted late at night, opium may be given to allay pain and secure rest, and the operation fixed for the following morning.

A sponge-tent should never be left in above twelve hours, and when removed, iodized or carbolyzed water should be freely injected into the vagina before attempting any further manipulation. If the cervix be already sufficiently patulous to admit the finger, or hemorrhage is not an urgent symptom, the insertion into the cervix uteri of a sponge-tent is uncalled for.

Having first seen that the bladder is empty, the patient should be placed close to the edge of the bed, in the dorsal or left lateral decubitus, as may seem most convenient to the individual practitioner. With one hand placed over the lower abdomen, the fundus uteri is then depressed, so as to enable the forefinger of the other hand to pass entirely into the uterus, when, if possible, the whole of the remaining ovum is swept out of the uterus. If this cannot be accomplished, the portion of

placenta within reach must first be detached and removed; the uterus then generally contracts sufficiently to bring the remainder of the placenta within reach, when the finger is again employed to sweep it out, or scrape it off from the uterine wall.

Firm pressure should be employed from above, and the finger should not be withdrawn until the uterus is felt to contract, so as to avoid the formation of clots in the interior.

It is well to inject the iodized water at 110° or 120° Fahr, through a metal tube or elastic catheter into the uterine cavity, to wash out any placental *debris*, and also to check further hemorrhage, should this be troublesome. A binder should then be applied to the abdomen, as after ordinary labor, ergot administered, and the usual precautions taken to promote convalescence.

In practice, it will, however, often be found difficult, if not impossible, to determine whether the whole of the placenta has been expelled, and it is in these cases that danger arises, whether from recurrence of hemorrhage, or from symptoms of septic absorption. If any doubt exist, it is better to explore carefully the cavity of the uterus. Denman long ago pointed out the fact that, where any portion of the placenta remains *in utero*, the cervix does not contract thoroughly, but remains more or less patulous. If symptoms of septicemia have already declared themselves, it may be unwise to insert a sponge-tent. If any difficulty be experienced in passing the finger sufficiently far up into the uterus to allow of placental *debris* being removed, the ovum forceps will here prove of much service. Having inserted them well into the uterus, the handles are separated gently and any projecting portion of the placenta seized and removed, the operation being repeated in a different direction until the whole of the contents have been secured. Where the uterus remains unusually bulky, hemorrhage recurs on the patient rising, or persists unduly long after the supposed miscarriage, or where the lochia are distinctly offensive in character, we may be pretty certain that the uterus is not yet empty. In place of contenting ourselves with the administration of ergot, our plain duty is to explore the cavity of the uterus. Instances have been recorded where portions of placenta have been extracted many months, and even years, after the miscarriage happened, no effort having been made to remove the cause, the symptom alone being treated.

The narration of a case of this nature may prove of interest as exemplifying practically the treatment indicated.

M. C., aged forty, had been married three years, up to which time she enjoyed most excellent health. She had a miscarriage six months after marriage, at the end of the second month, from which she recovered perfectly. Six months later a second miscarriage took place, and since which time she has never been thoroughly well. The periods, at first, were rather prolonged, but not irregular. About Christmas, 1884, serious hemorrhage took place, and since that date hemorrhage had been more or less constant, absent for a week or two, then suddenly beginning again. In November, 1885, she stated that she was subject to bursts of hemorrhage every two or three days, with watery discharges in the intervals. There was no pain at any time of any moment.

On examination, the uterus was found to be bulky, fairly normal in position, mobile, the uterine sound passing upwards and forwards three inches. The cervical canal was somewhat granular, and there was much glairy mucous discharge, but not offensive. The cervix uteri was dilated by means of laminaria tents. Ether was administered, and the interior of the uterus explored. Several portions of hypertrophied mucous membrane were scraped off with the curette, together with some small nodular masses. Linimentum iodi was freely applied to the uterine cavity, which was then syringed out, and ergot administered every few hours. There was no return of hemorrhage after this until about a fortnight subsequently, when the regular catamenial period came on, and lasted six days. The patient left for the country a month after her admission. Two months later, the husband wrote to me, saying, "There has not been the slightest hemorrhage of any kind so far, nor has there been any return of the period." There can be little doubt, I think, that the removal of some placental *debris*, together with some hypertrophied mucous membrane, constituting the so-called fungous endometritis, served effectually to arrest hemorrhage, and thus cure the patient.

In some cases, where the placenta is very adherent, and cannot readily be removed by the fingers or forceps, the blunt curette may be employed to scrape the surface, so as to remove all *debris*. This method is more often indicated in those cases where a portion of the placenta has been retained for many weeks or months after the incomplete miscarriage has taken place.

Syringing out the cavity of the uterus with hot iodized or carbolized water, at 110° to 120° Fahr., so as to remove all *debris*, where removal has been difficult, or where hemorrhage is free, often proves of much service in lessening the risk of septicemia. This may be repeated morn-

ing and evening for some days, if deemed requisite. Swabbing out the cavity of the uterus with liq. ferri perchlor. or linimentum iodi, where the discharge has been very offensive, or the placenta very decomposed, is indicated in some cases, but should not be resorted to as a routine-practice.

It is of great importance to keep the patient quiet in bed for at least a week or ten days, apply a binder firmly to the abdomen, as after ordinary labor, and resort to vaginal injections. If the lochia become in the least unpleasant or offensive, intra-uterine injections should be employed. Ergot and cinchona may be administered, with advantage, in most cases.

The administration of ergot is not an unmixed blessing. Where uterine action has already set in, ergot intensifies this action unquestionably; but if only a portion of the ovum be expelled, ergot tends to produce such an amount of contraction of the cervix uteri as to preclude further attempts at removal of the remainder. We may have to wait several hours until the influence of the ergot has passed off, before being able to insert the fingers or forceps to complete the delivery of the placenta. If hemorrhage be severe, ergot is, of course, indicated, and must be given; but, when the hemorrhage has ceased, it may be well to refrain from further administration of the drug until complete removal of the placenta has been effected, when its employment may again be persisted in. Where we have reason to believe that the whole of the placenta has not been expelled, and the hemorrhage continues, or recurs in the last exertion, and ergot fails in enabling the uterus to throw off the retained portion, its employment should be discontinued, and proper means adopted to extract the remainder of the placenta.

I have seen instances where ergot had been given freely and continuously for several successive weeks or months, without the desired effect being produced. This illustrates the abuse, not the rational use of the drug, and cannot be too strongly condemned.

It is with the hope of directing special attention to the absolute necessity of removing all placental *debris*, in these cases of incomplete abortion, that I have thought it worth while to occupy your time and attention on this occasion, and if I have succeeded in this, my object will have been fulfilled.—*Arch. of Gynecology.*

MORTALITY OF CESARIAN SECTION.—Dr. William H. Parrish, of Philadelphia, in a paper read at the recent meeting of the American Gynecological Society, gives the statistics of the Cesarian operation in the United States as follows:

Cesarian Operations in the United States.....	144
Women Saved, (37.5 per cent.).....	54
Children living when delivered, (44.4 per cent.).....	64
First fifty operations, saved 54 per cent.	
Second fifty operations, saved 24 per cent.	

Operations performed in good season when the condition of the woman was favorable, have in this country saved seventy-five per cent. of the women and eighty per cent. of the children. The operation has been performed in thirteen cases where the obstruction was due to fibroid tumors; of this number four women recovered and five children were living.

The rules laid down for the performance of the operation are:

1. Carefully determine the degree of obstruction and operate early in labor, as soon as the os is sufficiently dilated to permit drainage, and before rupture of the membranes.
2. Operate with full antiseptic precautions, but the spray over the abdomen is unnecessary.
3. Control hemorrhage by compression, either with a rubber tube or manually, preferably the latter.
4. Introduce numerous deep and superficial sutures so as to approximate accurately the muscular walls of the uterus, but do not carry the stitches into the endometrium. Removal of a section of the muscular wall is unnecessary.
5. Protect the peritoneum from the discharges and if it become soiled it should be carefully cleansed.
6. Ergotin should be administered at the beginning of the operation.

THE CESARIAN SECTION IN OHIO, according to Dr. Robert P. Harris, of Philadelphia, has a record as follows:

Women saved, 8; lost, 5; total, 13.
 Children living, 6; dead, 7; total, 13.
 Percentage of women saved, 61 7-13.

THE TREATMENT OF EXCESSIVE SALIVATION DURING PREGNANCY.—Owing to the ordinary insignificance of this ailment, few medical works

contain a lengthened account of it. Dr. Y. Schramm, however, had the opportunity, in the autumn of 1885, of observing a very severe case, and he has published some notes of it in a Scandinavian journal. Numerous remedies were employed with very little effect, for at first he imagined the salivation to be due to chronic mercurialisation; but, later, he discovered that the patient was pregnant, and that pregnancy was the cause of the condition. Neither the iodide of potassium recommended by Le Maestre nor Von Ebstein's atropine treatment had any effect. Galvanising the sympathetic also exercised only a very slight effect. Galvanising the cervical sympathetic was resorted to with no perceptible result. Dr. Schramm then tried subcutaneous injections of pilocarpin (as recommended by Von Labbe and Daveyex). After seven injections of pilocarpine chloride, $\frac{1}{6}$ grain per dose, there was a diminution of the daily quantity of saliva, as well as improvement in the general health of the patient. The excessive secretion, however, could not be entirely stopped. Bromide of potassium was tried, which acted quickly in the reduction of the flow; and Dr. Schramm prefers bromide of potassium to all other drugs, as it is harmless during pregnancy, and yet exercises a distinct effect on the salivary nerves, and on the origin of the facial nerve in the medulla oblongata, and also on the secretory filaments of the sympathetic. Professor Fleck made a chemical examination of the saliva, and found that pytaline was absent.—*Brit. Med. Journal.*

TREATMENT OF A FORM OF DIARRHEA IN CHILDREN.—There is a form of diarrhea in children, usually occurring after weaning, and from that period to four or five years of age, which is characterized by the most horrible offensiveness of the motions. This is so marked, that it is generally at once mentioned by the parents. It is commonly met with in summer, but is not strictly what is known as infantile diarrhea, in which disease the stools are sour, but not necessarily fetid. Probably this form of diarrhea differs from that of younger infants in being caused by the growth of the ordinary bacteria of putrefaction. It is not amenable to treatment by any astringent, nor has any alteration of diet much effect upon it. It may, however, be successfully treated by disinfecting the bowel-contents by means of salicylate of iron, as in the following prescription, which is suitable for a child two years of age. Sulphate of iron $\mathfrak{ij}$; salicylate of soda $\mathfrak{ij}$; glycerine $\mathfrak{z}$ ij; water to three ounces. The iron and the salicylate should be dissolved separately, and the solutions mixed. The color is darker than port wine, and the taste not unpleasant. One teaspoonful must be given every hour, until the stools become well blackened, which

happens in about twenty four hours ; or a larger dose may be administered at longer intervals. The medicine should then be given every three or four hours, and occasionally a small dose of castor-oil, to clear the bowels well out, and to get the secondary constipating effect of the oil.—*Brit. Med. Journal*.

The interval between marriage and the birth of the first child, is given in over 6,000 cases in a table prepared by Ansell. This gives a mean interval of nearly sixteen months. The majority are born before the close of the first year, nearly seven-eighths before the close of the second year. In 421 cases the first child was born after three years of married life, and before the fourth year was completed ; while in the years after the fourth there were only 222 taken altogether. From these data and similar results in other tables, Dr. J. Matthews Duncan concludes that married women delaying the commencement of fertility beyond six months, are already exhibiting a degree of relative sterility, and that when a married woman remains until the end of the fourth year without conceiving, the probabilities are strong that she will prove absolutely sterile.—*Southern Medical Record*.

THE EXTRACTION OF THE AFTER COMING HEAD.—From time to time, during the past few years, an animated discussion has arisen in the German medical press, as to the comparative merits of manual and instrumental extraction of the after-coming head in breech presentations, and after turning, especially in cases of contracted pelvis. Crede has been the foremost advocate for the use of the forceps, while Schroder and his followers condemn this practice, and recommend manual extraction alone.

A. Martin declares himself also in favor of manual extraction ; but, appreciating the danger to the child which undoubtedly attends the present manner of applying this method, he proposes a modification which he has practiced in thirty-eight cases with very good results. Instead of the usual method of placing the finger of one hand in the child's mouth, and hooking the fingers of the other over its shoulders and then pulling vigorously, throwing all the strain on the lower jaw and cervical vertebræ, Martin's plan is to introduce the middle finger of the hand, the palmar surface of which corresponds to the abdomen of the child, into the mouth, and make moderate traction upon the lower jaw, while the other hand is used to make powerful pressure upon the child's head externally and from above. Of thirty-eight children extracted, or rather expressed, in this manner, seven, or eighteen per cent., were stillborn, a result better than

that obtained by the forceps in the hands of Crede himself, who reports sixteen cases, of which four, or twenty-five per cent., were stillborn. In view, therefore, of the comparatively good results achieved, the wish expressed by Martin that the profession may at least deem this method worthy of trial will probably be gratified.—*Med. News.*

SHOULD THE HEALTHY CHILDREN IN A FAMILY WHERE MEASLES IS PRESENT BE KEPT FROM SCHOOL?—Dr. H. Wasserfuhr in the *Berlin Klin. Wochenschrift* answers this question in the negative. He thinks that the enforced idleness of four or six weeks is injurious; that the spreading of measles by a healthy child, though possible, is a very unlikely event; that practically, a regulation excluding such persons cannot be enforced, and that measles is a very mild affection if it attacks children in the school years. This view is one generally adopted, we believe, by sanitary officers in this country.—*Med. Record.*

TREATMENT OF THREAD-WORMS IN CHILDREN.—(Sidney Martin, M. D., M. R. C. P., in *Practitioner*.) The complete cure of thread-worms in children is often very difficult. While the ordinary methods used, such as rectal injections of salt and water, infusion of quassia, and other remedies, do good for a time, yet they often fail to relieve the attendant symptoms of "worms," symptoms usually very irregular, and in some cases severe, in character. In many cases, though the irritation about the anus is relieved by injections, the irregularity of the bowels and the disturbance of sleep remain the same. This is probably due to the fact that the habitat of the worms is higher up in the large intestine, where no remedy introduced by the rectum can reach them.

In many cases I have found that rhubarb in small doses brings away large numbers of worms, and at the same time regulates the bowels: so that the use of injections may in most cases be dispensed with. The formula which I have found most useful is as follows, varying slightly with the age of the child.

R Tinct. rhei m iij; magnesii carb. gr. iij; tinct. zingib. m. j; aq. ad 3 j.

This is to be taken twice or three times daily according to the effect on the bowels. Whether the rhubarb acts as a vermicide or simply by "moving the worms on," I am unable to say.

URINARY INCONTINENCE OF CHILDREN TREATED BY ANODYNES PER RECTUM.—Morphine alone relieves for the time being, but does not cure.

Belladonna and atropine are curative, when continued long enough, though they are better borne in combination with a little morphine, which counteracts some of their bad effects, and enables them to be given more continuously. Furthermore, the requisite dose of belladonna is smaller when combined with morphine. When these medicines produce headache or undue nervous excitability, I use the bromides as a corrective, or suspend their administration for a time. I have found no case where they could not be borne when properly given.

As to the mode of administration, a fifteen grain suppository of cocoa butter is most easily handled. They should contain a proper amount of extract of belladonna and morphine. For a child five years old, say, one-eighth of a grain of belladonna extract, and one-sixteenth grain of morphine; but the dose must be carefully adapted to the particular case in hand, beginning with a small dose, with a smaller relative proportion of belladonna, and increasing the latter and diminishing the morphine as toleration becomes established.

If an enema or clyster be preferred, it should consist of about a drachm of lukewarm water, with a few drops of atropia and morphine solution added.

As an illustration of this mode of treatment, a bright and charming pretty girl of fourteen came under my care for this disease July 9th, 1883. Had been subject to it for years, in fact nearly all her life. Was of a peculiarly sensitive nervous temperament, and subject to convulsions in infancy and early childhood, for which I had myself attended her. Was just beginning to menstruate. The urinary trouble had become a great source of mortification to her, and her shyness about it was great. I began with morphine alone, one-sixth of a grain nightly, in suppository. Failing to produce full relief I doubled the strength, making one-third of a grain, when she went nearly a month without once wetting the bed. On stopping the suppository the trouble quickly returned. Recommended the one-third grain suppository on September 14th, with full relief of the incontinence as before, but the patient, who was attending school all the time, began to get "fidgety" and nervous from the effects of the morphine, so that I was compelled to give small doses of bromide of potassium daily. This relieved the nervous symptoms entirely. I then began to taper-off on the morphine, giving a suppository every second or third night instead of every night. On this treatment she began to wet more frequently, and I became satisfied that morphine alone would not cure her. October 29th I prescribed a suppository containing one-

sixth grain of morphine and one-fourth grain extract of belladonna. On December 10th I made it one-eighth grain morphine and one-half grain extract of belladonna. Both these answered perfectly, and in six weeks she was practically cured. In the succeeding six months she did not wet more than six times, but each time was carefully followed by the use of the belladonna suppository for one week to prevent a relapse. For two years now, since the summer of 1834, she has been perfectly well and improved greatly in general health.

I might report other cases far more rapidly cured. I select the above on account of its long standing, and since I was obliged to proceed somewhat tentatively, as showing very well the comparative action of morphine and belladonna. The latter I have never given without some morphine, believing they act better in combination, as they do when given by the mouth. From present experience I believe the rectal treatment to be better than all others.

THE VARIOUS FORMS OF ECZEMA IN CHILDREN.—Professor Gran-cher. (*Journal de Medecine*.) Here we have four little eczema patients presenting very different appearances. The first has a simple impetiginous eczema of the face which appeared quite recently and which, despite its apparent severity, will disappear quite rapidly. It amounts to very little. The second case (aged 7) is more complex. The affection commenced when the child was five months old, and appeared upon the cheeks and eyelids. It has since continued almost constantly. The child has had for years the appearance of wearing a sort of dripping mask. She formerly contracted varicella, a complication which made the case a very interesting one. It was observed that the eruption of the varicella was much more confluent upon the parts originally attacked by eczema than elsewhere. During convalescence from varicella, the child's eczema greatly improved. It then contracted a light form of whooping cough, followed by severe diphtheritic angina, and, following these affections, the eczema completely disappeared.

In a third case, a child of twelve, the eczema was symmetrical, chronic and relapsing. The first attacks (at one year of age) lasted for a month or two, and occurred oftener as the child grew older. In the intervals of attack, the apparent cure seemed almost complete. The eczema, which was almost dry, commenced in the face, whence it spread to the arms and legs. Its character was pruriginous. During the child's stay at the hospital it was taken with a chill and an angina pre

ceding scarlatina. Before the eruption appeared the eczema suddenly took its departure. The scarlatina rash was very abundant and was strongly marked on the eczematous regions. The pruritus disappeared for ten days, and then the eczema returned with all of its former symptoms.

Another patient, who had been attacked three times before with eczema, followed by a scarlatiniform desquamation, came to the hospital with an acute attack, accompanied by intense fever which gave way rapidly to treatment. These four cases, so different, yet all of them attributed to "eczema," show how difficult it is to fix upon the true characteristics of the malady.

A Guiana gentleman consulted the greater part of European dermatologists for an eczema of long standing which covered his face with a veritable mask of vesico-pustules, and had extended to his arm. Various methods of treatment brought no relief. Certain topical applications ameliorated the condition of the arm to a certain degree, but the facial eruption remained stationary. Cod liver oil was prescribed, and the patient was soon able to take twelve teaspoonfuls a day. A month later there was a considerable amelioration of the trouble, and two months afterward the cure was complete. The patient has continued well for a long time, and compensates for the defect in his nutrition by taking a certain quantity of cod liver oil from time to time. The interest of the case centers wholly in the fact that it was cured by internal nutritive medication, and it is impossible not to see in it a demonstration that skin diseases are not local maladies so often as is supposed. Most of them are referable to a defect in nutrition and get well when that defect is remedied.—*Medical Abstract*.

BELLADONNA IN STERILITY OF FEMALES.—(J. Harris Jones in *New York Med. Journal*.)—There are few drugs which exhibit so pronounced a predilection to act upon certain structures of the body as belladonna. Among its favorite tissues, those of the female sexual organs may be mentioned. Its employment is followed by more or less benefit in every disease to which these parts are liable. I suppose it has fallen to the lot of almost every practitioner to be consulted by married women who were never pregnant as to the cause of their barrenness. Apparently they enjoy the best of health, and have never suffered from any irregularity of the sexual apparatus. To such I have on several occasions prescribed belladonna internally, and have found that, after taking the medicine for

some weeks, they become pregnant. I have seen this happen so often that I am constrained to regard the occurrence as something more than accidental. I shall not venture to theorize upon its action, but will merely mention that I have observed that the external genitalia become more relaxed, and the os and cervix uteri somewhat softened and pliable, during the treatment.

STERILITY AND OBESITY.—Dr. A. Brondel writes in the *Bulletin General de Thérapeutique* that he was consulted by a married lady on account of sterility, which caused her great unhappiness. The lady was excessively corpulent, so much so that the nurse was obliged to lift up the fat on the mons veneris with both hands before a speculum could be introduced. The genital organs were healthy. The patient was placed on a spare diet in order to reduce her obesity, and persevered in the regimen ordered for eighteen months, at the end of which time she had lost forty-four pounds in weight. The menses, which had formerly been irregular, returned, and the patient soon after became pregnant.

THE AMOUNT OF PRESSURE EXERCISED UPON THE FETAL HEAD BY THE FORCEPS DURING TRACTION.—The pressure upon the fetal head consists of three factors: (1) The “active” compression made by the hand of the accoucheur, while locking the handles; (2) the “traction-compression,” exercised by the forceps as the result of the traction; (3) the “passive” compression, effected by the pelvic walls. During the act of traction the pressure, as expressed mathematically, is directly proportional to the resistance offered by the head, and inversely as the friction and extent of the surfaces in contact. The power exerted by the hand of the accoucheur is inversely as the cosine of the angle between the blades, directly as the breadth and inversely as the length of the handles. The practical corollary is this—that it is desirable to increase the extent of the surfaces which are in direct contact with the fetal head; the ideal forceps should have short parallel blades and long handles.—*New York Medical Journal*.

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Polunius, O.

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ALOIN, PARV.....1-10 gr.

Med. prop.—A most desirable Cathartic.

The most useful application of these Parvules is in periodic irregularities—Dysmenorrhœa and Amenorrhœa. They should be given in doses of one or two every evening at and about the expected time.

DOSE.—4 to 6 at once. This number of Parvules, taken at any time, will be found to exert an easy, prompt, and ample Cathartic effect, unattended with nausea, and in all respects furnishing the most desirable aperient and cathartic preparation in use. For habitual constipation, they replace when taken in single parvules the various medicated waters, avoiding the quantity required by the latter as a dose, which fills the stomach and deranges the digestive organs.

CALOMEL, PARV.....1-20 gr.

Med. prop.—Alterative, Purgative.

DOSE.—1 to 2 every hour. Two Parvules of Calomel, taken every hour, until five or six doses are administered (which will comprise but half a grain), produce an activity of the liver which will be followed by bilious dejections and beneficial effects, that twenty grains of Blue Mass or ten grains of Calomel rarely cause, and sickness of the stomach does not usually follow.

PODOPHYLLINI, PARV.....1-40 gr.

Med. prop.—Cathartic, Cholagogue.

To Parvules of Podophyllin, administered three times a day will reestablish and regulate the peristaltic action and relieve habitual constipation, add tone to the liver, and invigorate the digestive functions.

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SURGERY.

PITFALLS FOR EXPERT M. D.'s.—(Dr. J. T. Woods, Toledo, in *Detroit Lancet*.) There is no place in which a medical man is more severely tried than when on the witness stand in the capacity of an expert. The pitfalls prepared by attorneys for his beguiling are as numerous as the ways that lead to them are seductive. I do not refer to the difficulties inherent in physiology, pathology and therapeutics, for they are infinite. To master the whole of them is beyond human power, and in their varied phases they come before us as experts for solution, or at least for explanation. That differences of opinion should arise among medical men in the labyrinth they present, is not a matter of wonder, however disagreeable and unsatisfactory it may be. It must also be remembered that the mind cultivated in matters medical at once grasps and understands that which does not reach the comprehension of others at all. His forms of expression, let him be as careful in the use of words as he may, are more or less new, novel, and measurably obscure even to judge and attorneys, and still more to the average juryman who expects to be enlightened. Further than this, they naturally insist that like causes produce like effects, and that a given disease in one should vary from one of the same name in another, they fail to comprehend. Their position would be correct, if it were not for the varying conditions. Let conditions be the same and a given cause will never vary in results, will be true in matters medical as in mechanics. But to define all the conditions is well nigh impossible, and he is happily endowed who can make a clear pathway. It is not my purpose to open up the whole subject, but rather to point out two of the more common rocks on which the expert is liable to be wrecked, the first of which is *inflammation*. A large proportion of the cases in which medical men appear as professional witnesses present this pathological feature in some of its varied forms.

The medical man habitually speaks of inflammation with familiarity, holding in his mind certain of its more pronounced signs. He knows it exists, that it is palpably present in the case. It is often amusing to hear the attorney as he guides the witness smoothly along, treating him with gentleness while he explains conditions and consequences. The witness chooses his words with care, and formulates his answers into sentences so as to convey his meaning as well as he may and, if possible, so that they shall be susceptible of only one interpretation. He has been questioned as to the patient's condition, has detailed the symptoms, the probable or possi-

ble results, under various circumstances, always speaking of inflammation as a thing, a distinct entity, when the lawyer with the utmost calmness on his face and the greatest possible satisfaction in his heart, blandly asks the startling query: Doctor, what is this inflammation about which you speak so complacently? The attorney who adopts this measure will be unsatisfied with these symptoms, and demand to know what the thing itself may be, and woe be to him who is not prepared with an answer in form of a definition. Generalizations do not satisfy, and abstruse disquisition is wholly obscure, and prying questions forced upon him in awkward and unwieldy form, are liable to lead to confusion and then to utter rout "horse, foot and dragoon."

Thus the testimony is broken down, because, as it appears, the witness is ignorant of that which is so nearly ever-present, with which he continually deals, and which it would seem he ought to be capable of defining; thus is all his learning and experience overshadowed by a cloud of doubt as to the value of his statements, his portion being discomfiture and mortification.

The second rock I desire to note is the question of *authorities*. All concede that certain ones of our number, either from a higher order of capabilities, better opportunities, or both these advantages combined, attain to a greater degree of both merit and distinction than others do, and are in consequence entitled to an enlarged degree of consideration.

These parties are esteemed as the foremost members of the profession, and their opinions rated accordingly by their brethren. From this point it is easy to pass to their recognition as authority. This idea is accepted, to a very great extent, by medical men, both theoretically and practically.

In discussion on professional subjects they are freely and reliantly quoted, in every day work their views are consulted, considered and esteemed, and not unfrequently followed blindly. Formerly, even within my own recollection, in a given class of cases, the medical attendant followed implicitly the routine course laid down by his favorite authors, and the patient, living or dying, had the satisfaction of knowing that the course taken on which his all depended, had at least the merit of having been dictated by a bright light, an accepted authority and power in disease and its treatment. At this time more individuality is exercised by the practitioner, whether for better or worse, I cannot determine. At least it is the fact that the patient now cannot rely more than indefinitely on living or dying according to the working direction of the masters, but

must fix his hopes on the ability, the culture, and earnest endeavor of the doctor into whose hands he commits himself. Knowing this estimate of the masters, the attorney avails himself of its use in dealing with the medical expert, and not unfrequently to his embarrassment. Through both observation and experience, he learns that medical men in their daily work do not usually *define* the actual causation, do not trace the line of cause and effect with that definiteness, that clearness, that is desirable on the witness stand. He knows that in examining a special case, few of them note for reference the points well and accurately observed, and then turning to authorities, investigate their views, and after mature and deliberate study of the whole, come to a conclusion, but relying on his general knowledge of the subject, aided by his analysis, and application of views and explanations as given by writers, ventures an opinion of his own, and this opinion he appears on the witness stand to maintain. In his examination in chief, his opinions are given, and his reasons therefor. These views may be entirely correct, but if they are satisfactory on one side of the pending case, they are exactly the reverse to the opposition. The cross-examination develops the same views, diversified with various forms of quibbling, efforts to add to or subtract from, often by misstating the positions taken to distort the evidence in chief so as to rob it of its value. At last comes the final effort at wrecking the ship and sinking cargo and all on board. I have been amused at the complaisance with which the attorney adjusts himself to the work. With refreshing suavity of manner, he looks over the medical books with which he has supplied himself, and arranges them in order on the table. Having carefully and calmly observed the title on the book, he then inquires of the witness if he is familiar with a work bearing a title which he reads, and by an author whose name he announces. The work being by an author and on a subject that if the witness has not read it carefully he will show himself to a bad advantage if he answers negatively, he can only commit himself to the statement that he is familiar with the writer as an author and the statements he makes in the book referred to.

The attorney will then probably indulge in some general inquiries as to the character of the author and the esteem in which he is held by the profession, concluding with the question as to whether the work referred to is not considered by medical men as an authority on the subject of which it treats. The answer to this being affirmative the whole is clinched by, "Do you consider it a good and reliable authority?" and the witness having gone this far can only answer "Yes."

The same course being taken in regard to each of the selected books, the destructive work is in earnest begun.

Opening one of the volumes, it is found to be book-marked, leaves are turned down and pencil lines show certain selected paragraphs. These choice spots are of necessity taken out of the article as a whole, and thus stated singly may not wholly convey the views of the author, but they are presented to the witness, when he is triumphantly asked what he thinks of and how he explains the difference of opinion expressed by his authority and that given by himself in testimony. Unfortunately, the witness is not so familiar with this article as he should be with the ten commandments. If he has ever read that particular chapter or section it may have been long since, and he is necessarily befogged and confused. To read the whole article is impracticable and to explain satisfactorily wholly impossible.

Thus paragraph after paragraph from authority after authority is presented until the overwhelmed witness is glad to be released while yet alive. He may know that in the case in hand the views stated by him are correct, but confronted by opposite, or at least varying, statements from his accepted authority, what can he say or do to clear away the difficulty? Neither he nor his attorney is at the time ready or prepared to show the fallacy. This would often be difficult even were it possible, the jury who are to arbitrate being unfitted to readily understand, comprehend and weigh the points on which explanation depends. A man trained to reading medical works, who instinctively grasps the intended meaning of words and sentences as used by medical writers might do this at a glance, but none others are capable, and a skillful perversion of authority has thus won a triumph over absolute fact and wrought harm to an honest and capable witness.

It is thus apparent that the question of authority is one of no mean importance, and hence worthy of consideration.

In this inquiry it may be remembered that medicine in all its departments, at any given period, is the result of observation, research, theory and practical experience. Commencing at a period we know not how remote, with a field of the most meager dimensions when history first gives notice of its existence, it has gradually expanded until its division into departments has become necessary, because of the limit of human ability and brevity of life. Step by step have precious methods been added to, or taken from; in every respect changing that which went before, so that going back a few years only, we find little of that now

accepted, and in the remote past only a trace of the medicine of to-day, nor have we reached the end. Earnest and able men are busy in every department and new views are continually presented to be refuted or confirmed by experience.

Hobbies, visionary fancies, absurd fallacies are as prevalent to-day, as in the time of Galen. Books and journals give us little grain in much chaff. Time alone can separate them, but the work of separation is going slowly on as it has for centuries. Books are the grain gathered by authors from the experience of others as stated by journals supplemented by their judgment and experience.

But even the great and capable differ in ability and in opportunity. They fail to see things exactly alike from the same data, and all do not have the same material to draw from. The result is that to some extent they differ from each other, and neither may be in possession of, or present the real fact. It follows that where it is possible for authorities to disagree, they are not authority beyond question, and especially so when discoveries made after the writing may show their views to be erroneous. It is also true that all great truths are not discovered by great men: all facts are not worked out in laboratories, but in the world of workers many there are, to the public unfamiliar, who are highly capable and who are in possession of facts and have real knowledge unknown to those who have attained high rank and written books for the guidance of their fellows. The consequence is that the medical man of to-day reads with attention and weighs in his own balance the views of his authority. He consults other authors on the same subject and at last accepts one or the other if they vary, or feels entirely free to disagree with either or both if in the use of his information and in the exercise of his judgment he is satisfied that they are in error. Coming to a given case in a certain class he recognizes that authors write of the class only, but he knows that in the group composing it, there are many shades of variety, that in fact no two are alike, although they seem so to him, his power of ascertaining a knowledge of all the conditions being wholly insufficient. It occurs to us all that not infrequently our patients live when so far as we can see they should die; and die when we are sure they will live. Fixed to a given case the author who writes of a class to which it belongs lays down principles that may not be applicable and may not be sustained in or by it.

In practice he should not follow such guidance wholly or blindly, but in the exercise of his judgment depart at the right point, and pursue

an independent course. Then why should he not do so on the witness stand, and meet the attorney who desires to tie him to an author as authority, by replying that "*the writer is of good repute among medical men, is a man of acknowledged ability; the book also holds a high place, but neither it, nor the writing of any man, is to me authority beyond question.*" He will be assailed at once by the surprised attorney, because of supposed presumption, to whose fierce questions he may reply calmly and confidently, no two authors writing on the same subject agree in every particular, any more than lawyers, judges, or the law itself. Decisions are often reversed in higher courts, and the supreme judges usually fail to agree on the same proposition after deliberation most mature. Just so medical writers may disagree. Whether they do on this particular point I am unable to say, but for these reasons decline to recognize any as unquestioned authority, and would not hesitate to disagree with all of them if I was definitely satisfied they were in error.

Thus the selected and detached paragraphs from the attorney's unendorsed authorities are valueless to him, and the witness left untrammelled to make clear and sufficient to the court and jury his views on the case in hand from the facts as represented to him.

MEASUREMENT OF LOWER LIMBS.—Prof. C. L. Ford, of the L. I. College Hospital, called attention, in 1862, to the fact that the lower limbs were not always of the same length in the human subject. This statement induced anatomists and surgeons to make an extended series of measurements, and the results confirmed the opinion expressed by Professor Ford. Garson, in the *Journal of Anatomy and Physiology*, sums up these observations. In seventy skeletons examined, he found the lower limbs equal in but seven. His measurements show that in 54.3 per cent the left was longer than the right. The right tibia was longer than the left in 41.4 per cent, and the two bones were found equal in but 10 per cent. The difference in the length of the lower limbs varies from one eighth of an inch to one inch and five eighths, without any deformity being recognizable. In a series of measurements of the collar bones, only six, in twenty-two cases examined, were found to be equal.

THE REMOVAL FROM THE SKIN OF PAPILLOMA, PIGMENTARY MOL AND SUPERFLUOUS HAIR. (Dr. Julia W. Carpenter, in *Lancet and Clinic.*)—Warty growths, pigmentary moles, and superfluous hair in conspicuous places sometimes give much discomfort. Among the many remedies for such cases glacial acetic acid has some qualities that highly recommend it. Its caustic properties are superficial, and thus the depth to which one wishes to penetrate can be easily controlled. It is painless when applied with proper care, the most that it causes being a little itching or very little smarting after the skin is broken. There seems to be no necessity for a resulting scar. In the many cases in which I have used it there was not left a mark of any kind, except in two, where, in spite of warning, the patient could not resist the temptation to pick at and pull off the little scab as it formed.

A fine looking young lady was annoyed by a pigmentary mole on the cheek, a little in front of the ear. It was about the size of a ten cent piece and little elevated above the surrounding skin. The acid was painted upon the surface and not allowed to pass over the edges. After several applications, with two to five minutes interval, the upper part was softened sufficiently to be removed with a little pine stick. One more application was made, when the tissue was softened to the required depth and removed as before. When the level of the surrounding skin was reached no more pigmentation remained. A thin scab formed, and when this fell off and the little resultiug redness had disappeared, there was an even surface of skin of natural color. There was no scar nor any trace of the former mole.

When these discolorations are elevated above the skin, I have so far removed them in this way, leaving, as in the case reported, an even surface of natural color, and no scar. If they are simply discolored spots and not elevated, there is left necessarily a little depression, and when one prefers the slight depression to the pigmentation they can be removed.

A conspicuous beard on the chin of an otherwise fine looking lady was easily disposed of in the following manner, taking out, of course, one hair at a time: A little pine stick, sharpened to a very fine point, was dipped in the glacial acetic acid and applied to the skin by the side of one hair, this hair being put slightly on the stretch, either with the fingers or fine pinchers. The skin, after touching it several times with an interval of a few moments between, is soon softened, so that the point can enter the hair follicle. The hair then comes out easily and another

application is made, letting the point pass as deeply into the follicle as it will.

About ten hairs were removed at a sitting, and when the work was completed the face presented a very different aspect minus its appendages.

Mrs. A., aged about sixty, came to consult me about the removal of a large warty growth on the bridge of the nose. She feared it was either a cancer or would take on eventually a cancerous degeneration. The growth had an almost circular base, about three-fourths of an inch in diameter. The elevation at its highest part was half an inch. The surface was rough, cracked, and had bled at points. The whole was encircled by a hard, inflamed ring. To test the nature of the case, soothing applications were prescribed to be applied several times daily upon this ring to see how much the inflammation could be reduced. In three weeks the redness and hardness had so far disappeared as to make it seem safe to remove the growth by this method. As a large scar in so prominent a place would be only less unsightly than the growth itself, it was necessary to proceed with caution. She being elderly and in rather feeble health, it was safest to test the healing power of the skin first by applying the acid to a very small part in the beginning. Accordingly it was applied at the base on the left side and a separation of one-sixteenth of an inch effected. No irritation was set up and it healed perfectly.

After waiting nearly two weeks, the healing power of the skin having proved to be excellent, the removal was again begun, and a little done each day until after ten sittings the last part of the mass fell off. A scab formed over all the surface, and when this fell off there was healthy skin beneath. And when after a few weeks all redness had passed away there was no scar nor the least trace of the former trouble.

The face was watched carefully for any return of the growth, but the skin remained perfect until the patient died four years later of pneumonia.

Many vegetations of the skin, as small warts on the face, and those little excrescences on the neck and shoulders that hang by a little pedicle or are cone shaped and attached at the base, are easily and quickly removed in this way, and no soreness results.

INTRACRANIAL HEMORRHAGES.—As a result of a study of 143 cases of fatal intra-cranial hemorrhage, Dr. H. F. Formad, of Philadelphia, thus concludes:

1. Hemorrhages exclusively above the pia mater and above the dura mater—*i. e.*, on the outside of the brain— are always due to *traumatism* or to *sunstroke*, provided a cerebral source for hemorrhage is excluded, and the cerebral vessels and membranes are not diseased.

2. Hemorrhage in the floor of the fourth ventricle is always traumatic, provided there are no blood-clots in the lateral ventricles, or any part of the cerebral substance.

3. Hemorrhage exclusively below the pia mater, or in any part of the brain substance, or into the ventricles (except the fourth) is always idiopathic—*i. e.*, is due to disease.

4. There must be diseased condition of the cerebral vessels or substance in order to ascribe a hemorrhage to disease. There must be *traumatism* (falls or violence) in order to account for a hemorrhage in a brain with normal substance and bloodvessels.

5. The blood-clot in concussion of the brain is not found at the point of application of violence, but usually somewhere about the opposite side of the brain, and always within the arachnoid—*i. e.*, between pia and dura mater.

6. The blood-clot in fractures of skull is always found at the point of application of violence, immediately below, and always between the dura mater and the fractured part of the skull itself. In rapidly fatal cases there is usually a second, an intradural clot (in the arachnoid) in some other part of brain, due to the effects of concussion.

7. A blood-clot formed within the cranial vault is more favorable to the patient if due to fractured skull than if due to a mere concussion.

8. Only clotted blood and infiltration of blood corpuscles into tissues indicate an ante-mortem hemorrhage; liquid blood is due to post-mortem oozing, and only stains, but does not infiltrate tissues.

9. Several bruises and cuts of the scalp may be seen in cases of idiopathic apoplexy, where a sudden cerebral hemorrhage causes a person to fall.

10. In some cases it is impossible to decide by medical examination alone as to whether a head injury and the resulting hemorrhage is due to a fall or to violence.

11. External marks of violence may be invisible to the unaided eye in some cases of injury of the head or other parts, but are easily detected and distinguished from post-mortem spots by means of the microscope.

12. The bulk of an intracranial hemorrhage stands usually in inverse proportion to that of the external scalp hemorrhage.

LIGATING ARTERIES. (Dr. Rennie, in *Brit. Med. Jour.*)—When picking up an artery of any size, give the vessel a complete twist on its own axis. It is easily done by twirling the forceps between the finger and thumb whilst holding them for the ligature to be applied. This accomplishes two things: first, by temporarily closing the artery, it prevents any blood oozing between the blades of the forceps; and, secondly, by freeing its divided end from the surrounding connective tissue, it causes it to "stand out" so that it can be easily seen and ligatured without any risk of including other structures. I have found this little manoeuvre so valuable in dealing with large vessels, that I venture to put it on record here.

IODOL, the new antiseptic which is said to have all the qualities of iodoform without its odor or toxic properties, is nearly insoluble in water (1 to 3) and in ether, chloroform and carbolic acid. Water cannot be added to the alcoholic solution without causing precipitation, but it will take its own bulk in glycerine. It dissolves in olive oil (15 per cent.) and in alkaline solutions. It is also used in fine powder and in ointment with vaseline. A good solution is made with 3 parts iodol, 35 alcohol, 162 glycerine. Iodol contains 90 per cent. of iodine. A solution of iodol, 1½ alcohol, 16; and glycerine 34, has been successful in causing the total disappearance of bad odors from carcinomatous ulcerations of the uterus and rectum. Gauze and collodion made with iodol are found to be superior to other similar articles. The action of iodol is similar to that of iodoform. It is probable that it deposits upon the parts to which it is applied, minute quantities of a modified iodine, and it is to this it owes its powers.

MEDICINE.

INHIBITION OF THE HEART IN DIPHTHERIA. (J. H. Gardiner, M. D., in *Can. Med. and Surg. Journal*.—The tonsils, pharynx, esophagus, stomach, part of the intestines, larynx, trachea, lungs and heart derive their chief nervous supply from the pneumogastric. It is true, however, that this is scarcely a simple nerve, seeing that it receives such large accessions from the sympathetic and spinal accessory, besides a full anastomosis with many of the special facial nerves, as well as with the general spinal nervous system. In that so many important vital parts are supplied from the same source, one need not be surprised that a very slight irritation to any one will give rise to symptoms far graver than what the apparent cause would lead us to expect. Tickling the throat with a feather, or bringing any nauseous substance into the mouth, induces vomiting. A slight sore throat causes headache, earache, backache, sickness at the stomach, and a horrible feeling of malaise. Any one who has suffered from quinsy or diphtheria will testify to the deathly feeling of sickness and exhaustion which these troubles give rise to. And most medical men of experience in the treatment of diphtheria will have met with cases similar to the following, or with cases where death supervened even more suddenly in persons where the disease appeared conquered and convalescence was apparently fast progressing :

CASE I.—Miss A., aged fourteen, first-class family and personal history, was, on the fourth day of February, 1884, attacked with diphtheria. The case was a severe one, and vomiting, with a partial loss of voice, marked it from the commencement. There was also a good deal of sloughing of the throat, and the urine was loaded with albumen. The symptoms continued violent for the first four days, and then the case began to do well. Pulse ranged from seventy to eighty. Temperature normal. Vomiting slight. Slough came away and membrane disappeared, as also did the albumen in the urine. The appetite improved, and everything pointed to a speedy recovery. On the morning of the twelfth—*i. e.*, on the eighth day of the disease—I was struck with the dusky appearance of the skin. The temperature was ninety-seven and one-half degrees, and the pulse fifty-five. In the evening the temperature remained the same ; pulse forty-eight, but impulse strong. During the day, patient vomited once. Was quite cheerful, however ; said she felt better, and wanted to get out to the dining-room. On the morning of the thirteenth, patient says she is better. Vomited once through the

night. A small herpetic rash on upper lip, at left angle. Skin dusky. Pulse forty, very feeble. Heart-beat regular and well-marked. At two P. M., pulse thirty-eight; countenance anxious; patient cheerful as to recovery; said she felt quite well, but weak. In the evening, pulse very feeble, and only thirty-two. Patient vomited a good deal during the day. Thirsty. Site of slough on throats looks grey. No membrane. Temperature ninety-seven. Feb. fourteenth.—Had a restless night, but friends thought her better. Cheerful but very weak. Could not make out the pulse at the wrist. Heart beats thirty-eight. Vomits nearly everything but little pieces of ice. Died from syncope at 2 P. M.

CASE II.—Miss H., aged five years; previous health good; family history good. Attacked with diphtheria on the twentieth of June, 1886. Case mild during first week, and membrane had almost disappeared. June twenty-seventh.—Pulse sixty; temperature normal; vomited once or twice. Twenty-eighth—Pulse fifty in the morning and forty-five at night; vomiting. Twenty-ninth—Pulse forty, fairly strong; thirsty, and vomits now and then; herpetic eruption on face; in the evening, pulse thirty-six; temperature ninety-seven and one-half degrees. Thirtieth—Pulse thirty-two, soft and compressible, and father says that he has counted pulse at five A. M., and found it only twenty-eight; temperature ninety-seven degrees; patient restless, but intellect clear; vomiting. July first—Pulse very feeble, forty in morning and forty-five in evening. Second—Patient died in fainting fit at four A. M.

I cannot say what an autopsy would reveal in cases like these. I would suppose that there would be heart-clot, but this would not explain all the symptoms, or the same slow pulse would be observed in other cases of death from this cause. I have not noted such in cases where a post-mortem proved such formation. That the local paresis following some cases of diphtheria is due to a disturbance of the nutrition of the nerves through the sympathetic, would be inferred on account of the insidious manner of its advent, the extent to which it spreads, and the slowness of recovery. But this, although it would explain the vomiting and prostration, will not explain the retardation of the heart. The experiments of physiologists show how the heart's action may be retarded by galvanization of the pneumogastric. They also demonstrate that it is in branches derived from the spinal accessory that its power chiefly lies. Now the pharyngeal, recurrent laryngeal and cardiac branches of the pneumogastric receive large accessions from the spinal accessory, and the tonsils, pharynx and the upper part of the esophagus are supplied from

the pharyngeal nerve. Hence the peripheral ends of this nerve are subject to the direct local irritation of the disease. And from this a reflex action may be transmitted to the brain, or a peculiar irritation may be transmitted directly to the heart on account of the close relations existing between the heart and the affected parts. But if it is true that this irritation of the nerves is the cause of the inhibition, why do all cases of diphtheria or throat affections not present like symptoms? This I will answer by asking another question: Why are all wounds not followed by tetanus? You will answer that it is only when the nerves are affected in a certain manner, and the system is in a proper condition for the spread of the disorder from the periphery to the center, that this dreaded disease supervenes. So a peculiar condition of the organization is necessary for a diphtheritic irritation of the pharyngeal nerves to cause inhibition of the heart.

THE INUTILITY OF LIME PHOSPHATES.—The person who shows that a particular drug is of no value in therapeutics does a service to science, much more, perhaps, than by introducing a new remedy. M. E. Logeais, in the *Bulletin de Therapeutique*, aims to prove that the phosphates, and particularly the lime salts, are useless drugs. This seems at first very much like flying in the face of a wise Providence, established pharmaceutical interests, and sound therapeutical principles. The use of the phosphates in rachitis, defective bone nutrition, and all forms of functional nerve troubles is very common, and has received the support of eminent authorities. M. Logeais, however, quotes the experiments of Lehmann, Heiden, and Veiske, who claim to have demonstrated that the phosphates of lime added to the food are not absorbed, but are excreted in their entirety in the dejections. Dujardin-Beaumetz is quoted as saying that this salt has no action whatever, while Destage states, as a result of careful analysis of urine, that neither the phosphates of lime nor phosphoric acid is absorbed. To this may be added the statement of Nothnagel and Rossbach: "Never, as far as we know, has a case of rickets been cured by the administration of lime." "Everywhere there is a lack of trustworthy and extensive observations," as to its utility. All the forms of lime salts used in practice are, according to M. Logeais, precipitated and made insoluble as soon as they pass the stomach. They are, therefore, taken up, if at all, in the stomach alone, and the amount absorbed here is very small. The practical conclusion that lime salts of all kinds are therapeutically useless, is one which deserves the attention of the many physicians who are constantly prescribing them in various conditions.—*N. Y. Medical Record*.

INSOMNIA IN THE AGED.—D. C. L. Dana (New York Bulletin of Clinic. Soc.) has found the information contained in the text books upon insomnia in the aged to be but very slight in amount. Insomnia was not frequent in the aged, but when it was present it was sometimes very intractable. In his experience iron did not relieve the anemia of the aged so as to produce sleep. Alcohol with food was another remedy, and many recommended hot gruel with alcohol before going to bed. While alcohol will relieve some cases, there are others in which the insomnia was increased. The bromides and chloral, even when given in enormous doses, often fail to give relief. Opium was another remedy. Good results have been obtained with a combination of cannabis indica and codeia; from five to six minims of the fluid extract of cannabis indica with one-eighth of a grain of codeia might be used. One-fourth of a grain of the extract of cannabis taken alone sometimes might be effective. As a rule, however, the combination with codeia was preferable. Hyoscyamine was sometimes useful, but in nervous, fidgety persons it would sometimes produce an actual delirium. Under ordinary circumstances the dose should not be increased above one fourteenth of a grain to obtain the desired effect. The effect of these remedies, he thought, had been increased by the addition of from two to three drops of tincture of aconite two or three times a day to relieve the tension of the blood-vessels. Tincture of valerian and compound spirits of lavender sometimes acted like a charm in relieving insomnia. Large doses (፻i-፺i.) of lupulin were also often effective.—*New England Medical Monthly*.

The Syrup of Hypophosphites (the formula of which was published in our last issue) is prepared as follows:—Dissolve the iron lactate, magnesium, ammonium, potassium, sodium, and manganese hypophosphites and the citric acid, in about three pints of warm water, the calcium chloride in ten ounces of water, and the strychnine in one ounce of water, by aid of the hypophosphorous acid; mix all the solutions, add the sugar, and dissolve it by agitation, filling up with water to within an ounce of a gallon; when the sugar is dissolved, add the quinine muriate and oil of orange, both dissolved in the alcohol; mix well and strain. The syrup should be kept in well corked, amber-colored bottles, holding one pint or less, as the light and air oxidize hypophosphites to phosphates, some of the latter being insoluble.

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We are endeavoring to get down to a cash-in-advance system.

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The law requires all who take a publication from the post office regularly to pay for it. No reputable publisher will knowingly send a publication to those who do not wish it, yet the above law is just and necessary for protection of publishers.

Strange to say, some persons receive a journal several years and then write that they did not want it. Such are, of course, required by law to pay.

Look out for bills in December and July numbers.

We send a receipt in the first issue of the JOURNAL after payment.

Read carefully our Premium List, next to page 250.

The Paul E. Wirt Fountain Pen offered in our Premium List, is the best ever made and guaranteed satisfactory, or can be returned. It is a plain gold pen, with no valves, springs, or machinery to get out of order.

Heating and Ventilating.

The connection of the heating of a house with its ventilation is, of course, inseparable. Many persons will cheerfully expend ten or fifteen thousand dollars in building a house, putting from two to three thousand on outside ornaments, who would not dream of spending five hundred or one thousand dollars for the necessary Hot Water Apparatus to keep this same house thoroughly and comfortably warmed and well ventilated.

In reading the reports from the various Boards of Health, one can not fail to notice the startling increase in the death rate from Scarlet Fever, Diphtheria, and allied diseases. It might safely be said that this condition of affairs is due to the fact that the tightly closed doors and windows, which cold weather makes necessary, prevents the ventilation of houses, which is essential to the maintenance of health.

To those who intend erecting a dwelling, we would advise that the matter of heating and ventilating be given much consideration; and before deciding how it shall be done, consult the A. A. Griffing Iron Co., Manufacturers of the Tompkins Hot Water Indirect Radiator, 518 Communipaw Ave., Jersey City, N. J.

Fluid Forms of Hydrastis.

The reputation of this drug as a therapeutic agent was first gained through its employment in the form of an *infusion*; and in the fifty years following its introduction into medical practice, a continuous effort has been made by manufacturers to perfect a preparation which would represent all the active principles of the drug, without the high price of the salts, either alone or in combination.

The most prejudiced writers on *Materia Medica*, accord to the late Wm. S. Merrell the largest share of credit in the introduction of Hydrastis preparations, and to the present organization the reputation of being the *largest consumers of the drug in the world*. For more than a half-century, Hydrastis has been made a study in our laboratory, and we do not think we exaggerate its importance when we assert that it stands pre-eminent to-day as the most valuable exponent of our vegetable *Materia Medica*.

The following preparations *in fluid form* are receiving our special attention at this time:

Fluid Hydrastis—MERRELL.

Is what its name implies—the active, medicinal principles of the drug in natural combination and in a fluid form. It has a bright, yellow color, perfectly clear, free from sediment, and with an unmistakable odor of the *fresh drug*.

Fluid Hydrastis is a pure, neutral solution of all the alkaloidal constituents of the drug, rejecting the oil, gums, irritating and offensive resins and inert extractive matters. The success attending its introduction is the best evidence of its therapeutic value.

Unsuccessful imitations and would-be substitutes are met with on every hand. Preparations said to be “just as good” or “about the same thing,” but always “a little cheaper,” attest the wide-spread and growing popularity of Fluid Hydrastis. All such, compared with the latter as to physical appearance or as representatives of the drug, *are condemned*; dispensed in prescriptions, *they are readily detected*; tested therapeutically, they are *promptly rejected* as unworthy of confidence.

Fluid Hydrastis is applicable to the treatment of all irritable, inflammatory and ulcerative conditions of the mucous tract.

This statement of a well-known medical writer and journalist has become axiomatic:

“No remedy for physician's use has been received with such universal approval.”

Solution Bismuth and Hydrastia—MERRELL.

An invaluable and scientific combination, wherein the beneficial action of the white alkaloid is increased by association with Bismuth. This solution contains $2\frac{1}{2}$ grains of the double Citrate Bismuth and Hydrastia; twenty-five per cent. of which is Hydrastia Citrate.

The cordial reception accorded this preparation marks it as the most valuable combination in the market in which the white alkaloid alone represents the valuable properties of the drug. Used in diseases of the nasal passages, of the eye, of the throat, of the stomach and intestines, of the reproductive organs and bladder it is equally beneficial.

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This is a permanent solution of the white alkaloid, without the addition of any other medicinal agent to modify or increase its action. It is offered without special recommendation to meet the views of an unlimited number of physicians, with whom the color of the Fluid Hydrastis is an objection. This solution contains in one fluid pint the same proportionate strength of white alkaloid as exists in an average quality of crude root.

See notes above on Solution Bismuth and Hydrastia.

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CINCINNATI.

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EDITORIAL DEPARTMENT.

J. F. BALDWIN, M. D., Columbus, - - - EDITOR.

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HANN & ADAIR, Publishers, Columbus, O.

THE friends and alumni of the Columbus Medical College, of this city, will be pleased to learn that the West Virginia Board of Examiners will hereafter admit the diplomas of that school to the registration which has been denied them since 1882. The causes which led to the action of the Board in 1882, we need not now review: they are familiar to most of our readers. By this recent action they have in no sense rescinded or revoked their action of four years ago; holders of diplomas, issued during these four years, are still embargoed.

To secure the present result, the College simply promised to comply with the requirements of the Board; when it was at once, under a standing rule of the Board, accorded future recognition: that rule being that any black-listed college will be restored to recognition on giving "satisfactory evidence of an intention to maintain the standard of requirements adopted by the Board." The Dean's letter is verbatim as follows:

COLUMBUS, OHIO, July 24th, 1886.

DR. T. A. HARRIS, Secretary of the Board of Health of West Virginia.

Dear Sir, Your letter of the 19th inst. containing the resolutions passed by your Board at its late meeting, as well as the offer on your part to lay before the Board any assurance of the part of the Columbus Medical College "that the College does and intends to meet the requirements of the Board" is received. I am ready to state as dean of Columbus Medical College: 1st, that in no instance since the case of Dent has Columbus Medical College varied a particle from the requirements of its Announcement which are enclosed; 2nd, in no instance shall it be done hereafter; 3d, Columbus Medical College will endeavor to comply in all respects with the requirements of the Board of Health of West Va., in so far as they relate to maintaining the standard of Medical Education. 4th, I recognize the graduation of Dent was irregular, and

the action of the College in his behalf was not warranted by, but in conflict with our published requirements.

Will you indicate any thing further which I can do to further the solution of the difficulty between the Board and the College.

Yours Respectfully, D. N. KINSMAN,
Dean Columbus Med. College.

The editor of this JOURNAL, ignorant of the fact that any such action was in contemplation, had already, viz., on the 9th of July, personally communicated to Dr. Harris his belief that the school had of late been complying with its published requirements, and that, being now in possession of a hospital, its diplomas were as much entitled to registration as those of scores of other schools. This statement was made as a mere matter of justice, disregarding all personal feelings.

But it must be the occasion of sincere regret to many, that what has now been done was not done, as it might just as well have been, four years ago, when a member of the faculty was incontinently ejected from his chair for putting into a private letter what is now, to all intents and purposes, virtually acknowledged to the Board officially, by the chief officer of the college.

We are glad, if only for the sake of Columbus, that this stain upon one of its schools has been removed; and we sincerely hope that the school will hereafter so conduct itself as to escape the disciplinary action of Boards of Registration and Examination.

HEALTH VS. HEATING AND VENTILATION.—The heating and ventilation of our houses has so much to do with the health and comfort of the inmates that it surprises us that it receives so little attention. With the proper appliances used, the vitiated or foul air is removed, and a supply of fresh admitted, but when such precaution is ignored, the germs of disease gain an easy foothold, and scarlet fever, diphtheria, and other kindred maladies assume a malignant type. Parties building would do well to dispense if necessary with some extravagant ornamentation, and supply their homes with a good hot-water heating and ventilating apparatus, such as that brought out by Mr. Samuel D. Tompkins, engineer, and manufactured by the A. A. Griffing Iron Co., 518 Communipaw ave., Jersey City, N. J., which meets all the conditions required; *i. e.*, cheapness, durability and effectiveness; the latter, however, being the most prominent. We thank the A. A. Griffing Iron Co. for the handsome illustrated circulars mailed us, both of their hot water heating and ventilating apparatus, and their numerous constructions for steam uses, and we think

those who may be building or about to build would do well to consult the above firm before purchasing heating appliances.

A MEDICAL JOURNAL CLIQUE.—In an editorial in the *St. Louis Medical and Surgical Journal*, appears the following statement: "During the meeting of the American Medical Society in this city last May, a mutual admiration club was organized by the editors and representatives of certain medical journals published in various parts of the country, with the very laudable object of keeping each other well before the reading public. The motto of this club was 'You scratch my back and I'll scratch yours,' and members pledged themselves to copy as much as possible from each other."

That such a clique should have been formed is somewhat humiliating; but that it exists cannot be doubted, and it would not be very difficult to name the journals.

THE FORUM, which reaches our table monthly, is filled with the very best of material. For the December number, W. S. Lilly, one of the foremost philosophical thinkers and writers of England, has prepared an article which is likely to command wide attention, on "The Present Outlook for Christianity." He holds that the belief of Christendom stands absolutely intact and unassailable from the point of view of science.

SUBSTITUTION.—The profession in general fails to realize how much injury is done to themselves and their patients by the substitution of spurious, or the so called "just as good," preparations, in place of goods of standard reputation?

The following letter from Dr. Springer is a case in point.

VAN BUREN, OHIO, Sept. 10th, 1886.

Messrs. Battle & Co., St. Louis, Mo.

GENTLEMEN:—In the case of "Insomnia," which I reported to you in May last, and wherein it required seven drachm doses (hourly, 1 drachm) to produce sleep by Bromidia brought at a pharmacy in Findlay—it required but one drachm, repeated in *one* hour, to produce a good night's rest, of the sample bottle you sent me. I also use the Bromidia (Battle & Co.) with the best results in "cholera infantum," and in "hysteria." *Am satisfied that the article bought at Findlay was "Spurious."*

GEO. SPRINGER, M. D.

DR. R. HARVEY REED recently read a very interesting paper, on Ptomaine poisoning, before the Mansfield Lyceum. The Doctor believes in keeping the people posted on sanitary matters.

NEW ETHERIZER.—Dr. D. E. Keefe, of Springfield, Mass., has devised a new etherizer. It consists of a large towel rolled into the form of a hollow cylinder, and stiffened by a cylindrical backing of newspaper. In other words, it is constructed much after the manner of the usual cone, except that the shape is that of a cylinder equally open at each end. In use, ether is poured into the towel and the apparatus placed over the patient's face; as soon as the mucous membranes become accustomed to the ether, which is thus largely diluted with air, the sides of the upper end of the cylinder are brought together, so that air is excluded and only pure ether administered. He claims excellent results.

RIO CHEMICAL COMPANY, OF ST. LOUIS.—We acknowledge the receipt from this company of a box containing a full line of the articles regularly advertised in this journal. Their Celerina as a nerve tonic, Aletris Cordial, as a uterine tonic and sedative, Acid Mannate as a pleasant aperient, and Extract of Pinus Canadensis as a non-irritating astringent for mucous surfaces, have received the approval not only of ordinary general practitioners but also of many who are eminent in their specialties.

WE cannot too strongly urge upon our readers the necessity of subscribing for a family newspaper of the first class—such, for instance, as *The Independent*, of New York. Were we obliged to select one publication for habitual and careful reading to the exclusion of all others, we should choose unhesitatingly *The Independent*. It is a newspaper, magazine, and review, all in one. It is a religious, a literary, an educational, a story, an art, a scientific, an agricultural, a financial, and a political paper combined. It has 32 folio pages and 21 departments. No matter what a person's religion, politics or profession may be, no matter what the age, sex, employment or condition may be, *The Independent* will prove a help, an instructor, an educator. Our readers can do no less than to send a postal for a free specimen copy, or for thirty cents the paper will be sent a month, enabling one to judge of its merits more critically. Its yearly subscription is \$3.00, or two years for \$5.00.

Address, *The Independent*, 251 Broadway, New York city.

The Youth's Companion maintains its reputation for publishing the best Serial and Short Stories, as well as striking stories of adventure. The next volume will contain the eight prize stories selected as the best from over 5,000 manuscripts sent in competition, for which \$5,000 has recently

been awarded. Narratives of travel by celebrated explorers, biography, history, science, hygiene, recreation—and many more subjects, are represented in it. Its contributors are the most noted writers of this country and of Europe. Among them are W. D. Howells, J. T. Trowbridge, Prof. Huxley, The Duke of Argyle, The Marquis of Lorne and Princess Louise, Archdeacon Farrar, C. A. Stevens, Admiral David Porter, Lieut. Schwatka, and many others. It is no wonder that the *Companion*, with such contributors, has nearly 400,000 subscribers. It costs but \$1.75 a year, and a subscription sent now is credited to January, 1888.

The Scientific American, referred to in another column, under the heading of "Patents," is the very best publication in this country for those interested in science, engineering, mechanics, inventions, etc.

Literary Note. *The Archives of Gynecology, Obstetrics and Pediatrics*, New York, series of 1886 just completed, has met with such warm encouragement, the publishers have decided to issue monthly, and commencing January, the parts will so appear, instead of bi-monthly as heretofore. It is published by Leonard & Co., 141 Broadway.

COCAINE ADDICTION—MR. EDITOR: If any reader of your journal has met with a case of Cocaine addiction and will send me the fullest details at his command, I'll thank him for the courtesy, reimburse him for any expense incurred, and give him full credit in a coming paper.

J. B. MATTISON, M. D.,
Brooklyn, 314 State St.

TYPHOID FEVER SPECIMENS:—Dr. James E. Reeves, of Wheeling, W. Va., is making a very thorough microscopical study of typhoid fever, and will be obliged to any members of the profession who will send him the spleen, kidneys, mesenteric glands and a piece of liver, of patients dying of that disease.

DR. H. A. TOBEY, of Lima, formerly of the Central Ohio and Dayton Insane Asylums, has just been elected Superintendent of the North-Western Ohio Insane Asylum. A better selection could not have been made.

FOR SALE.—House of six rooms, and office neatly arranged. Large stable, just new. Can insure unusual large practice. Collections No. 1. Will take \$800.00 cash, if offered within a few weeks. Address,

DR. F. L. KINSEY, Fort Seneca, Ohio.

CORRESPONDENCE.

LETTER FROM MR. TAIT.

EDITOR OF THE COLUMBUS MEDICAL JOURNAL, SIR:—I have just read in the International Journal of Medical Science, an article by Sir Spencer Wells, in which, speaking of chronic inflammatory disease of the uterine appendages, that distinguished and entitled Surgeon asks the extraordinary question, "Who can diagnosticate the presence of irreparable disease in these out-of-the-way organs?" I hail with delight and satisfaction, an answer in your journal on page 105, from the pen of Dr. Charles A. L. Reed, of Hamilton, Professor of Gynecology at the Cincinnati College of Medicine and Surgery, which shows that in your distant land you are further advanced in the appreciation of modern progress in pelvic surgery than Sir Spencer Wells, in the English metropolis, can claim to be. The details of these cases of Dr. Reed, and the conclusions he arrives at, are eminently satisfactory to me, for they are quite coincident with those which I have already detailed. The obstructive ignorance which is displayed on this subject on this side of the Atlantic, by some men who ought to know better, is perfectly amazing.

I am etc.,

LAWSON TAIT.

SOCIETY PROCEEDINGS.

THE ASSOCIATION OF SURGEONS TO THE PENNSYLVANIA COMPANY.

The Eighth Semi-Annual Meeting of the Association of the Surgeons of the Pennsylvania Company was held October 19th, 1886, at the Seventh Avenue Hotel, in Pittsburgh, Pa. There was a full attendance of the surgeons off of both the Pennsylvania Company's lines and the Pan Handle System, filling the parlors of the hotel to their utmost capacity.

Heretofore the Association has only embraced the Pittsburgh, Ft. Wayne & Chicago, Cleveland & Pittsburgh, Erie & Pittsburgh, North Western Ohio, Ashtabula & Pittsburgh, New Castle & Beaver Valley, New Brighton & New Castle, Alliance, Niles & Ashtabula, Massillon & Cleveland, Indianapolis & Vincennes, and Lawrence railroads; but at

this meeting they extended their territory by taking in the entire South West System, or what is popularly known as the Pan Handle System, embracing all of the Pennsylvania lines west of Pittsburgh, amounting in all to 2481 miles of road. This is with perhaps one exception the largest association of railroad surgeons in the world.

The Association of Surgeons to the Pennsylvania Company was organized at Crestline, Ohio, October 24, 1882, and at that time was the second organization of its kind in America. The object of its organization was "to increase the efficiency of the surgical service of the Company and to promote an interchange of ideas among its members concerning railroad surgery," and at the same time to secure the best system possible for caring for the company's wounded, with the greatest dispatch, the least amount of pain to the injured, and the smallest expense practicable to the company.

At the recent meeting the papers read showed a degree of care in their preparation that at once gave them merit and standing before the Association. A paper on Compound Comminuted Fractures, by Dr. Mont. Linville, of New Castle, Pennsylvania, was short and to the point. Although not strictly advocating antiseptic treatment of the wound, he advocated all possible cleanliness.

Dr. R. P. Johnson, of Canton, Ohio, read an interesting paper on "Anesthetics," which called out quite an extended discussion on the different kinds, and the ways of using them.

"Trephining after railroad injuries" was the subject of a carefully prepared paper by Dr. E. W. Lee, of Chicago, who advocated the free use of the trephine, and always under the strictest antiseptic precautions.

Dr. A. W. Ridenour, of Massillon, Ohio, reported "A Novel Amputation" of a part of the foot, which under antiseptic dressings resulted in a very satisfactory cure.

A decidedly meritorious paper was read by Dr. G. A. Shane, of Steubenville, Ohio, on "Amputation for Mortification following Traumatism."

The discussion of the above papers was continued until 2 P. M., when the Association adjourned for dinner, after which the Company took the Surgeons, through the kindness of Dr. Buchanan & Son, in a special car to the West Pennsylvania and Allegheny Hospitals.

The Association resumed the further discussion of the papers at 7 P. M., and did not adjourn until 10 P. M., having given 8 solid hours of

work to the business of the meeting, when they adjourned to meet at Crestline, Ohio, in May, 1887.

This being the annual meeting, the following officers were elected for the coming year: President, Dr. J. H. Tressel, of Alliance, Ohio; Vice Pres't., Dr. E. W. Lee, of Chicago, Ill.; Sec'y. and Treasurer, Dr. J. J. Buchanan, of Pittsburgh, Pa.; Executive committee, Drs. A. W. Ridenour, Massillon, Ohio, S. S. Thorn, Toledo, Ohio, and G. W. McGavren, Van West, Ohio.

Resolutions of regret were passed by the association on the resignation of Dr. J. H. Davisson, of Warsaw, who was obliged to go west of the Rocky Mountains, on account of his health, and also Dr. P. B. Young, of Crestline, who went west on account of his wife's illness, and Dr. R. P. Johnson, of Canton, who is about to remove South.

REVIEWS AND BOOK NOTICES.

The Medical News Visiting List for 1887.—Philadelphia; Lea Brothers & Co. Contains Calendar for two years. Obstetric diagrams. Scheme of Dentition. Tables of weights and measures and comparative scales. Instructions for examining the urine. List of disinfectants. Table of eruptive fevers. Lists of new remedies and remedies not generally used. Incompatibles, Poisons and Antidotes. Artificial respiration. Table of doses, prepared to accord with the last revision of the U. S. Pharmacopeia, an extended table of Diseases and their Remedies, and directions for Ligation of Arteries. Blanks for all records of practice and Erasable Tablet. Handsomely bound in limp Morocco, with tuck, pocket, pencil, rubber and catheter scale. The list is issued in four styles, viz.: Dated, for 30 patients per week, 1 vol.; dated, for 60 patients, 2 vols.; dated, for 90 patients, 3 vols.; undated (perpetual), 1 vol. Price per volume, \$1 25. Also, furnished with Ready Reference Thumb letter Index for 25 cents additional.

This visiting list is one of the best, and, when furnished with the thumb letter index, the very best, in the market.

Physician's Visiting List, (Lindsay & Blakiston's) for 1887. 36th year of its publication. Philadelphia: P. Blakiston, Son & Co., 1886.

This has been for many years a very popular visiting list. It is the smallest and lightest list published, is well made, and is cheap. Is arranged for 25, 50, 75 and 100 patients, dated and undated, plain and interleaved. See advt. in this issue.

A Treatise on the Principles and Practice of Medicine, Designed for the Use of Practitioners and Students of Medicine. By Austin Flint, M. D., LL. D. Sixth Edition, Revised and largely Rewritten by the Author, Assisted by William H. Welch, M. D., etc., and Austin Flint, M. D., LL. D. Philadelphia, Lea Brothers & Co., 1886. 8vo, pp. 1160.

We need add little to the notice of this work which appeared in our last issue. By condensation and rearrangement, and the omission of obsolete matter, much new material has been added to the present edition without materially increasing its bulk. We notice the following new articles: Infectious Tumors, Syphilitic Disease of the Lungs, Cerebral Syphilis, General Considerations relating to Inflammatory and Structural Disease of the Spinal Cord, Spastic Cerebral Paralysis of Children, Hereditary Ataxia, Myxedema, Multiple Neuritis, General Pathology of Pyrexia, and Milk-sickness. Some diagrams have been introduced to elucidate the physical diagnosis of cerebral diseases.

A Manual of Animal Vaccination. Preceded by considerations on vaccination in general. By Dr. E. Warlomont, Founder and Director of the State Vaccine Institute of Belgium, etc. Translated and edited by Arthur J. Harris, M. D., Senior Asst. Phys. to St. John's Hosp. for Diseases of the skin, London, etc. Philadelphia: Published by John Wyeth & Bro. 1886.

In this work, Dr. Warlomont presents an admirable *resume* of the existing knowledge on the subject of vaccine, and he supplements the whole with the results of his own vast observation. No branch of the subject has failed to receive enlightened consideration, and, although he seeks to establish the superiority of the animal over humanized lymph, he exhibits no prejudices against the latter, and only pronounced for the greater utility of the former, after a rigorous analysis of all the facts bearing on the question.

We have heard numerous expressions of satisfaction over the establishment of a vaccine farm by Messrs. Wyeth & Bro., and we doubt not their enterprise in issuing this *brochure* will be fully appreciated.

Courier Review Call-Book — A physician's Pocket Reference Book and Visiting List, arranged and prepared by E. M. Nelson, M. D., Ph. D., editor St. Louis Courier of Medicine, etc. etc. St. Louis: J. H. Chambers & Co.

This visiting list is perpetual, not being dated. The list proper follows twenty-six pages devoted to various matters on which a doctor's memory is liable to need refreshing, including a very complete table of doses, thermom-

etric scales, diet table for diabetics, &c. It also has the usual pages for memoranda, etc. In shape it is somewhat different from other lists, being thinner and wider, so as to fit better the breast pocket.

Outlines of the Pathology and Treatment of Syphilis, and Allied Venereal Diseases. By Hermann Von Zeissl, M. D., Late Professor at the Imperial-Royal University of Vienna. *Second Edition, Revised.* By Maximilian Von Ziessl, M. D., Privat-Dozent for Diseases of the Skin and Syphilis, at Imperial Royal University of Vienna. Authorized Edition. *Translated, with Notes,* by H. Raphael, M. D., Attending Physician for Diseases of Genito-Urinary Organs and Syphilis, Bellevue Hospital Out-Patient Department, etc. New York: D. Appleton & Co. 1886. 8vo. Pp. 402. Cloth \$4., Columbus: Geo. H. Twiss.

The name selected for this book is unfortunate; it should have been instead—"Practical Treatise on the Venereal Diseases."

While the part devoted to syphilitic affections of the skin is unchanged in this edition the chapters on gonorrhea, epididymitis, strictures, chancres, and syphilis—including visceral and hereditary, have been entirely rewritten. The articles on the syphilitic affections of the larynx, trachea and eye, have been furnished by Professors Schrotter and Mauthner. The book is a most excellent one in every respect, and the translator has done his work well.

Bright's Disease and Allied Affections of the Kidneys. By Charles W. Purdy, M. D., Queen's University, Professor of Genito-Urinary and Renal Diseases in the Chicago Polyclinic, etc. 8vo., 288 pages, with 18 illustrations. Cloth, \$2. Philadelphia, Lea Brothers & Co., 1886.

This work is a systematic, practical, and concise description of the pathology and treatment of the principal organic diseases of the kidneys, associated with albuminous urine. The author has given more prominence to scarlatinal and puerperal nephritis than has heretofore been done by writers on this subject.

Authorities, ancient and modern, are quoted concerning the etiology of uremia, but the author himself very candidly leaves the question open.

Nephritis he divides simply into acute and chronic. Cirrhosis, including its semeiology and treatment, is fully considered, together with amyloid kidney and cyanotic induration.

The text is illustrated with a number of engravings from original drawings, chiefly representing morbid anatomy. We regard this as one of the best monographs yet published on the subject.

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COMMUNICATIONS.

ASEPTIC SURGERY.

BY R. HARVEY REED, M. D., MANSFIELD, OHIO.*

Read before the Annual Meeting of the Muskingum Valley District Medical Society held at Zanesville, Ohio, November 26th, 1886

By "Aseptic Surgery" we mean that system or method of performing surgical operations, and dressing of wounds, by which perfect cleanliness is secured, by the systematic use of antiseptics in the form of either irrigation or sprays; where the best possible coaptation of parts is observed and suppuration is prevented, in whole or in part, by the use of proper germicides, or when suppuration exists to any extent, to favor its immediate removal by thorough drainage, by which, together with perfect rest of the injured parts, aided by the best possible sanitary surroundings and hygienic care, union is secured by first intention with little or no constitutional disturbance.

When the immortal Lister announced to the world his methods of dressing surgical wounds, scarcely fifteen years ago, and reported his wonderful results from their use, almost the entire surgical world "laughed him to scorn" and looked on what then seemed the wild fancies of a "crank" or the imaginary reports of a prevaricating char-

*Surgeon for the B. & O. and Pennsylvania Railroads.

latan, without foundation or reality; and few surgeons were charitable enough to even make a fair trial of his methods and thus demonstrate their value for themselves. It is true that few surgeons to-day have adopted or put in practice Listerism in its purity; yet the leaven of Listerism has been and is still at work among the surgeons of our land, until it hath more or less "leavened the whole lump." There is scarcely an active progressive surgeon at the present time who has not adopted the *principles* first advanced by Lister, and is not now practicing the same in some modified form, and who could be induced to drop it for the old fashioned ways of dressing wounds with salves and so-called "healing ointments." So universally is this the case that few men will dare to deny the fact that since Listerism has been announced it has almost revolutionized surgery, and has made operations not only possible but practicable which only a few years ago would have either been looked upon as hazardous or not have been attempted at all.

Prior to the practice of aseptic surgery who ever dreamt of an amputation of the leg or arm uniting with primary union, in a few days, and without the formation of a drop of pus? What surgeon would have believed an amputated breast could have been healed entirely in nine days, with but little pain, and no suppuration, ten years ago, nay, how many five years ago? Prior to the introduction of aseptic surgery, who would have even suspected the possibility of making a ten or twelve inch incision in the abdomen and removing a thirty or forty pound ovarian tumor, and that by simply tying the pedicle, and dropping it back into the abdomen, and closing the internal and external wounds aseptically, it would take on primary resolution and recovery occur without a drop of pus and but little constitutional disturbance! And yet these are actual realities that astonish the whole surgical world, and although as little thought of a few years ago by the rank and file of the profession, as that we would talk from Chicago to New York and recognize our brother's voice, yet just as much a reality, and have wrought as great a revolution in the surgical world, as the telephone has in commercial circles.

When Prof. James L. Cable's able paper was discussed at the meeting of the American Surgical Association, in 1882, "On Sanitary Conditions in Relation to the Treatment of Surgical Operations and Injuries," many of our leading American surgeons (most of whom admitted, however, they had never as much as tested the Lister principles of antiseptic dressings), opposed the radical changes necessary to the use of Listerism,

in their surgical practice; but on the other hand many of those who opposed Listerism in its purity, had adopted stricter sanitary conditions in their surgical practice; while others were practicing some modified form of Listerism. Said Dr. Nancrede, of Philadelphia*, "Listerism aims at depriving wound fluids of the power of putrefaction," and "because a man gives up the spray, the cry should not go up that he has given up Listerism;" he says further, "they say the system of Mr. Lister is troublesome; it is not more troublesome than other methods, and if it were, we should not consider the trouble, when the life or comfort of a fellow man is in question. I tried it for several years, then I gave it up for several years, and now I am going back to it." Dr. Geo. W. Gay, surgeon of the largest hospital in Boston, which averages from 1600 to 1700 surgical cases a year, says: "After using this practice for five years in this large hospital, and seeing other cases of like character treated by other methods in the same ward, (one surgeon having one side of the ward and one the other,) I feel convinced that I can do a few things with the Listerian dressing that cannot be done without it. There is no way in which you can keep a wound free from odor and check profuse suppuration so quickly as with the antiseptic dressing. I am as sure of this as I am of my name."

Prof. Briggs, of Nashville, says in his excellent paper,† "No single method of wound treatment can constitute the antiseptic method *par excellence* to the exclusion of others. I hold that true antiseptic surgery applies to the employment in the treatment of wounds, of all measures and agents that will most effectually prevent wound disorders, especially putrefaction, or if they cannot be prevented, that will remove or render nugatory their evil effects. So general is the practice of antiseptic surgery, and so great the faith of the profession in the necessity of its observance, that bold indeed must be the surgeon who, in the face of the revolution and experience of the past few years, would deny its virtue or dare neglect its teachings. While all acknowledge, however, the great value of antiseptic surgery, its practice is of infinite variety. One class of surgeons tries to anticipate and prevent putrefaction; another attempts to seal the absorbent surface, and thus to shut out its products. One leaves the wound open for the ready escape of the enemy, another closes the path of entrance so that he cannot enter. All, however, seek the same end, namely, to prevent putrescent matters from forming in

*Transactions of American Surgical Association, Vol. I, page 76.

†Transactions of American Surgical Association, Vol. I, page 137.

wounds, or to remove them before they have produced their injurious effects. To treat wounds of every kind after the same method would be as absurd as so treat every disease with the same medicine."

In discussing Dr. Briggs' able paper, that veteran surgeon of Rochester, N. Y., Dr. E. M. Moere, said: "I think that we shall all agree with the views expressed. The great advantage of subcutaneous surgery we all know. The advantage of getting rid of the air has been repeated many times to-day. This, of course, is what Mr. Lister tried to do. He attempts to purify the air which comes in contact with the wound.

Dr. Watson, of Jersey City, in his earnest plea for Lister's system of aseptic wound treatment,* says the adherents to the Lister treatment have steadily increased in number, but there are some surgeons who still oppose it. This opposition is entirely maintained by those who have never practiced the Listerian system. We are now satisfied that the majority of surgeons are prepared to admit that the *system, or method of practice* which gives the most complete rest to the wound while it is healing, and at the same time the most complete immunity from septic complications, is the one which will always yield the best results."

Volumes of opinions from eminent surgeons could be quoted favoring the aseptic treatment of wounds but such would be occupying your time unnecessarily, and those who are not satisfied with the few quotations already made, I will refer to the general literature on this subject in which Dr. Cheyne's *Antiseptic Surgery*, a valuable little book of over two hundred pages, is perhaps among the best.

As "the proof of the pudding is in the eating," let us see what some of the results of aseptic surgery have been.

Dr. A. C. Girard, of the U. S. A., who visited the Lister hospitals while abroad a few years ago, says: "Who before this, would have fearlessly opened the knee-joint for suppurative arthritis, as I saw done under the spray? the patient recovering in a few days with a sound joint. Who would have expected an ovariectomy with general adhesions in a woman of seventy-five to heal in eight days without a symptom of reaction; or a laparotomy for the liberation of an incarcerated peritoneal hernia in a moribund patient, healing in six days, or a resection of the ulna in nine days? Take the results of such prominent men as Bardelen and Billroth; surely they cannot be considered as being dirty or careless; they have performed some 300 or 400 operations with a mor-

*Transactions of the American Surgical Association, Vol. I, page 211.

talities of about 29 per cent. Taking about the same number of amputations, of about the same gravity, performed by Nussbaum, Volkmann, Locin and Lister, with the antiseptic system, the death rate was only 4 per cent."

In between 500 and 600 osteotomies by MacEwen he had only three deaths in all, one from diphtheria, one from meningitis, and one from some other cause, but not from septic complications. McCormic in 1879 reported forty-five hospital operations for the division of various bones for the removal of deformities, of which thirty embraced operations on the knee-joint, every one of which recovered "in the speediest, easiest, safest manner possible, under antiseptic precautions." Dr. J. Ewing Mears states that "erysipelas and sloughing wounds have been entirely banished from St. Mary's Hospital in Philadelphia, by rigid antiseptic methods, the hospital being situated in the midst of railroads and factories, and receiving every year a large number of severe injuries."

Mr. Thornton, of the Samaritan Free Hospital, says that by rigid adherence to the teachings of Lister, he has succeeded in lowering his rate of mortality in ovariectomy from 23.94 per cent. to 4 per cent. In his first set of cases, which were non-antiseptic and extra-peritoneal, the mortality was 23.94 per cent; second set, non-antiseptic and intra-peritoneal, 19.35 per cent.; 150 antiseptic cases, all intra-peritoneal, 10.00 per cent. Of the 150 ovariectomies treated by Mr. Thornton antiseptically there were :

- 50 with no adhesions, all recovered.
- 30 with slight adhesions, all recovered.
- 70 with extensive adhesions, 15 died.
- 15 in private houses, all recovered.
- 6 in nursing houses, all recovered.

Dr. Simon Baruch, of New York, (*Medical Record*, Jan. 30, 1886.) says: "It would be an act of supererogation to defend Listerism at this late day. What treatment, either ancient or modern, has presented a better record than this, furnished by Alanson; 35 great amputations without a death, or of Syme, 20 cases without a death, of Percy, 92 cases with six deaths, and of Lucas, 70 cases with five deaths. The statistics of modern surgery abound in better records, Neuber, of Keil, reported to the Congress of German Surgeons in 1880, 83 major operations, of which 60 healed under one dressing, without a single death, while Dr. Oberst in his work reports 261 cases with only 14 deaths, ten of which

died from collapse, one each from tetanus, anemia, exhaustion, and habitual erysipelas."

Dr. Cabell, in closing his able paper, says: "It is the part of wisdom to use every possible precaution against the development of septic conditions. That the Listerian precautions do avail to this end, the experience of Spencer Wells, Dr. Goodell and Dr. Homans abundantly proves. Operating under identical conditions in all other respects, they found a notable difference in the results of their antiseptic and non-antiseptic cases;" as Mr. Keith has said in the *British Medical Journal* for Oct. 19, 1878, "by antiseptics we had the following gains: 1st, it lessened mortality; 2nd, earlier operations may be safely recommended; 3d, drainage might in a measure be superseded; 4th, convalescence was rendered easier; 5th, it had brought great comfort and relief to the operator."

The question may now be raised as to what the fundamental principles of aseptic surgery are? This is answered in the following brief postulates, by Prof. Briggs, of Nashville:

"1st. Pathogenic germs are always found in the atmosphere.

"2nd. These germs, if allowed to come in contact with open wounds, have the power not only of causing putrefaction, but also of entering the tissues around, and, by their rapid increase, pervading the exposed region and of spreading their evil effects throughout the entire system.

"3d. The entrance of these germs into open wounds is the sole cause of all septic accidents."

These principles being practically true, aseptic surgeons seek to remove or prevent their injurious effects by "1st, careful preparatory treatment; 2nd, judicious after-treatment; 3d, removal of foreign bodies; 4th, perfect cleanliness; 5th, accurate coaptation of the edges and sides of wounds; 6th, thorough drainage; 7th, maintainance of equable temperature; 8th, methodical compression; 9th, position; 10th, rest."

Whilst proper aseptic dressings will prevent injured tissues from receiving further injury from the effects of the myriads of pathogenic germs, and thereby becoming devitalized, yet it must be remembered that devitalized tissue resulting from a severe injury cannot be revitalized by any dressing. The surgeon is often called on to dress extensive wounds resulting from railroad injuries, or those sustained by massive machinery, falls, blows, or gun-shot wounds, where large masses of tissue

apparently are little injured, but in reality are so devitalized as to rapidly die and slough, no matter what kind of dressings are used.

At other times it is a question as to the propriety of removing *all* the injured tissues, and operating in the sound flesh. For various important reasons, and with the hope of saving all the tissue possible, flaps are sometimes made, or skin covering used, of injured structures, which are expected to slough more or less. Under these circumstances the brilliant results cannot be expected of aseptic dressings, as when it is applied to wounds having no injured structures remaining in them, yet it gives better results under the worst circumstances than any other form of dressing.

It seems to me the most prejudiced mind could not help being impressed with the importance of aseptic surgery if he will only take the pains to witness a few operations, or results of such treatment in the surgical wards of any of our hospitals using the same. I remember visiting the Milwaukee Hospital, which is under the care of my friend Prof. N. Senn, who is one of the strongest advocates in the West of aseptic surgery, and after examining case after case of his in the surgical wards, which had been operated on by him for various maladies and dressed antiseptically, I found all yielding the same general results, of primary union without suppuration, or, if any at all, but little, and almost no constitutional disturbance.

Dr. Buchanan, jr., of Pittsburgh, in a paper read before the Surgeons' Association of the Pennsylvania Railroad,* in speaking of antiseptic dressings, says, "there is no irritative fever; the temperature rarely rises above 101° F., and usually not over 99° or 100°. The advantages of this system of dressing are rapidity of healing, absence of high temperature, freedom from suppuration, and in most cases immunity from blood poisoning." Since the reading of the paper just referred to, Dr. Buchanan, sr., of Pittsburgh, has reported several major amputations, with recovery, and not a drop of pus occurring in any one of them.

Here, gentlemen, are the dressings from four different cases dressed aseptically which I present for the purpose of showing you as proof of the assertions I have made, and not that the cases themselves are of any particular interest.

Number one is the first dressing from a patient operated on June 14, 1886, by Dr. J. W. Craig, in the presence of Drs. Race, of our city, J. H. Craig and myself. The operation was performed on Mrs. C., aged about fifty, for an old umbilical hernia, and consisted in removing a large

**Ft. Wayne Medical Journal*, Vol. V, page 2.

portion of the omentum, and returning the rest, together with the intestine, and closing the wound with quill sutures and also a few silver sutures, and dressing antiseptically, which was not disturbed for seven days, when it was removed and a new dressing applied. The dressing is stained with blood, but has no pus on it, and not a particle of smell, notwithstanding the hot weather following the operation. The wound was almost entirely healed at the time of the dressing, and the patient made a rapid recovery with little or no constitutional disturbance.

The second dressing is that from a patient who had his hand caught in a buzz-saw, tearing out the metacarpal bone of the little finger, which was almost entirely severed from the hand, and lacerating the soft parts in a terrible manner, involving the superficial palmar arch, making an opening nearly eight inches in length. I dressed the wound antiseptically, June 15th, and did not remove the dressings until June 23, when I found the dressings as you see them, only slightly stained with serum, but not a drop of pus; the wound was almost entirely healed, by first intention, whilst the patient had suffered little or no pain and had not a particle of constitutional disturbance. Unfortunately, however, a piece of wood, driven deep in the flesh under the palmar arch, escaped detection, and afterwards suppurated until discovered and removed, when the wound healed completely in a few days.

Number three is from an amputation of the breast, in an old lady of sixty, for scirrhus, in which I was assisted by Dr. Craig and Son. The incision was six inches in length; the entire gland was dissected out and the wound dressed antiseptically, and not disturbed for seven days, when I removed this dressing, which is free from pus, only slightly stained by blood, and perfectly sweet and clean, with no odor, excepting that of the iodoform. The wound almost entirely healed by primary union, which, at the second dressing a week later, was found complete and the patient dismissed. There was scarcely a particle of constitutional disturbance, the pulse never exceeding 88 and the temperature $99\frac{1}{2}^{\circ}$, and that only for one day; the remainder of the time both were perfectly normal, while the patient did not lose a night's sleep, did not have any pain, nor use an anodyne, and had a good appetite all the time.

Number four is from a compound comminuted fracture of the ulna near the elbow, in which there was complete dislocation of the head of the radius, with marked contusion of all the surrounding soft parts. It was the result of a railroad accident, occurring in a man of forty. The short end of the ulna was protruding through the integument,

and when first examined by Dr. Craig, sr. and the writer, we thought amputation would be forced upon us, owing to the opening being so near the joint and the extreme laceration of the soft parts, saying nothing of the comminuted condition of the ulna. After adjusting the fragments of bone, I dressed the wound antiseptically, and did not remove the dressing until the seventh day, when I found the wound had almost healed and not a drop of pus had been formed; another dressing of the same kind was applied and the wound healed without further trouble, the bones all united, and with the exception of an ankylosed joint, which was naturally expected. The man made a rapid recovery, and returned to work in less than eight weeks.

Such cases could be multiplied if necessary, but I deem these sufficient, for as it hath been said in olden times, "by the mouth of two or three witnesses shall every word be established."

In an editorial on "Some points in the Treatment of Compound Fractures," (*Jour. of Amer. Med. Ass'n*, Nov. 20, 1886,) it is said, "according to the most reliable statistical tables, the mortality of compound fractures in hospitals before antiseptics was from 26 to 68 per cent. Since the introduction of antiseptics, the death rate has fallen to four per cent. These magnificent results, as we all know, are due to the science of bacteriology, and for such the profession is indebted to Sir Joseph Lister, whose name can never be disassociated from the march and progress of surgery."

As to the best disinfectants for surgical use, I will refer you to Major George Sternberg's prize essay on Disinfection &c.,* in which he places corrosive sublimate at the head of the list of sterilizing preparations and says: "Mercuric chloride is an efficient antiseptic in the proportion of one to 15,000, and it exercises a restraining influence upon the development of the spores of the anthrax bacillus, when present in culture solutions in the proportion of one to 300,000 and even less."

Carbolic acid, on the other hand, is not nearly so efficient as an antiseptic, and much more dangerous, especially in open wounds, unless used as an escharotic and thus seal the mouths of bleeding vessels at once, and prevent its absorption, which is seldom necessary, and a more or less dangerous practice, owing to the inflammatory results from using such strong solutions, while the mild solutions are more readily absorbed, producing their toxic effects on the economy.

In speaking of carbolic acid, Dr. Sternberg says: "A saturated

**Amer. Public Health Ass'n.*, 1885, Page 111.

aqueous solution cannot, however, be relied upon for the destruction of spores ; but in the absence of spores it is fatal to micro-organisms in the proportion of two per cent. (or 1 to 50) the time of exposure being *two hours*."

There are many forms of antiseptic dressings, but from the writer's limited experience, I have learned to prefer the irrigation of the wound with a solution of mercuric chloride of about the strength of one to 3,000 or 4,000; using this in sufficient quantities to cleanse the wound of all foreign substances and blood clots before attempting to close it, prior to which I dust the wound completely with iodoform before taking a suture, and, after closing it with a hemp, silk, catgut or kangaroo tail sinew suture, (the former two being well waxed with carbolized white wax, one drachm to the ounce,) I again dust the seam of the wound with iodoform, after which I cover it with a pad of sterilized cheese-cloth and absorbent cotton, (the latter I sometimes dust full of iodoform also,) and then apply the ordinary roller bandage over all ; it is seldom that a wound dressed in this manner will need looking at for a week, yet if for any reason I find there are indications of it not doing well, such as pain, swelling, or constitutional irritation, I do not hesitate to open it, and the sooner the better ; usually, however, it needs no further attention for a week, when it will be found united, or nearly so, by first intention, which a second dressing will generally complete.

In cases where it is necessary to use drainage tubes, I usually extend them outside of all the dressings, using a temporary seal for their mouths of absorbent cotton dusted with iodoform, which can be easily removed and allow them to discharge and then be replaced, so as to prevent the entrance to the heart of the wound, through an open drainage tube, of atmospheric germs. I never retain the drainage tubes a moment longer than is absolutely necessary, for just as soon as their work is done, they become a useless foreign body.

Experience has convinced me that the surgeon who carries out this general form of dressing, or any other plan of aseptic dressing, meanwhile observing that the hands, knives, needles, ligatures, sutures, and dressings are all thoroughly cleansed, and sterilized by some efficient antiseptic, will on the average have better success, with less pain to his patients, and trouble to himself, than the surgeon who relies on the old time methods of treating surgical injuries with dressings of rags and salves. In fact, I believe the day is not far distant when the surgeon who does not see to it that every practicable antiseptic precaution is observed in the dressing of surgical injuries, will be held responsible for the same at the bar of justice.

COLDS IN CHRONIC CATARRHAL INFLAMMATION OF THE NOSE, THROAT AND EARS.

BY THOS. M. RUMBOLD, M. D., ST. LOUIS, MO.

THE COURSE OF COLDS.

In many respects a cold contracted by a healthy individual, is like a fire kindled in a wooden building. In the beginning, both the fire from the match and the cold affecting the patient are trifles, as both can be controlled with but little exertion; a small quantity of water proving sufficient to extinguish the fire, and a little attention to terminate the cold. But if allowed to progress unchecked a bucketful of water will be necessary to accomplish what might have been done by a teaspoonful, and even if the bucketful is not dashed upon the flames *at the right time*, the fire will have gained such headway as to result in the utter destruction of the house. So with a cold. If proper hygienic care, and, may be a very little medication be promptly resorted to at its inception, it can be readily controlled with but little inconvenience to the patient, while if neglected at this stage, its ill effects, probably, will steadily increase, until magnified into weeks, perhaps months of suffering, possibly ending in death.

The early history of every case shows that chronic catarrhal inflammation of the superior portion of the respiratory tract, has its origin in cold in the head; also that the growth of the inflammation is almost imperceptible. The first cold causes so slight an inconvenience, as to be scarcely noticeable, while each succeeding attack is a little more severe, of longer continuance, and at much shorter intervals, until the intervals between them are obliterated altogether, a fresh cold being contracted before the previous one has entirely disappeared. At this stage of the disease, the membrane in many cases is so sensitive that the slightest draught of air, or even a fall of the barometer, will suffice to occasion an attack so severe as to involve the entire respiratory tract. While a great deal of exposure was necessary to produce the earlier colds, as the disease grows in severity, each succeeding one is contracted more easily, until the patient is unable to ascribe a cause for the last attack, but fully realizes he is in the power of the disease.

THE EFFECT OF COLDS.

The immediate result of every cold is enlargement of the blood vessels in the part affected. If the cold continues for several days, or is

allowed to pass off *slowly*, the muscular coat surrounding the blood vessels will have lost some of its contractile power, and the vessels will remain somewhat enlarged. When the irritation which caused the congestion is removed, the vessels will be more liable, because of their atonic condition, to become affected on taking the next cold; and if the next cold is contracted before the blood vessels have entirely recovered from the dilating effect of the preceding cold, it will produce a congestion still greater than the former cold, causing a consequent still greater dilatation of the vessels, leaving them still more enlarged, weakened and relaxed, when this cold has passed off.

THE WAY THAT CHRONIC CATARRH IS CONTRACTED.

Thus, each successive cold prepares the sufferer to take cold more easily, and more severely. Every person who is a victim of a chronic catarrhal inflammation, has acquired it in this, *and no other way*. It is the only way in which the disease can originate.

Every person should constantly bear in mind that while a cold is slowly *wearing off*, the chronic catarrhal inflammation is slowly *wearing on*. This shows that it is very important that colds should be cured as quickly as possible. It also as plainly shows that it is of the utmost importance to prevent the renewal of colds by the proper observance of hygienic rules.

Patients may not be able to entirely prevent the recurrence of colds in the head, but they can render successful treatment of the disease possible, by diminishing the frequency, consequently the severity, of the attacks. *If such precaution be not taken*, the inflammation will extend to other portions of the respiratory tract, or to the auditory organs, in defiance of all therapeutic measures that can be instituted.

The importance of attention to hygienic measures gains weight when it is known that with the young, the inflamed membrane, if protected from repeated attacks, will gradually regain its healthy condition. In other words, if young patients could be so protected that they would not take another cold, they would slowly recover with but little if any medical aid.

In all cases, under the combined influence of hygienic and therapeutic measures, the mucous membrane generally loses its extreme susceptibility to take cold, and the prominent and urgent symptoms of the complaint gradually disappear.

In conclusion, I will say that the successful treatment of every patient may be likened to the successful suspension of a chain; if any one

of its links is broken the chain drops. It may be said that one of the links dependent upon successful treatment of this disease, is called protection of the head, neck, body and extremities; another link, danger of exposure to draughts and night air; another, maintenance of the nasal and aural passages in a clean condition, if catarrhal secretion is profuse; another, abstinence from the use of tobacco and spirituous drinks, and so on, through the whole list of hygienic and sanative measures, and the last and the least link, called therapeutic measures. Now if any one of these links is broken—it makes but little difference which it is—success will not follow the treatment of such a patient.

COLDS INCURRED FROM DRAUGHTS, NIGHT AIR AND BY PETTY ACTS OF
COMMISSION AND OMISSION.

Most persons know from experience that while they are in an over-heated condition, it is unwise to expose the head, neck and shoulders, or any limited portion of the body, to a current of cold air. Many refuse to bear patiently the temporary discomfort of an over-heating, and to obtain relief, take a seat at an open window, thereby incurring a cold, which, in the most trifling cases, will last double as many days as the discomfort from the over-heating would have lasted half hours, and in many instances a cold contracted in such a manner proves to be so serious in results as to affect the health of the victim during the remainder of his life, even if it does not shorten life itself.

Exposure to night air should be avoided if possible. If compelled to be out at such a time, more clothing should be placed around the neck and chest than is worn during the day. It would be well for females who must so expose themselves, during cold or damp weather, to draw over their shoes a pair of thick woollen stockings, long enough to reach to the knees.

Sitting for three or four hours in a hot theatre or lecture-room, where the air is impure, succeeded by a ride in the street car or an open carriage ten or twelve squares—equal to an exposure of half an hour—is sure to be followed by an increase of all catarrhal symptoms, unless precautions are taken to ward off a cold, by placing extra protection on the head, around the neck and on the lower extremities. In addition it would be well to protect the hands and wrists in cold weather, the former by woollen mitts the latter by woollen wristlets or pulse warmers, as they are popularly called.

In the care one should take of themselves, there are many petty acts of commission and omission, the result of forgetfulness, or more frequently

of carelessness, which almost surely originate a cold. The most conspicuous of which are, sitting on a stone door-step in a cool evening to a late hour in the night; sitting up late after the fire in the room has gone out, then going to bed with cold feet; getting out of bed with bare feet and in night-dress to wait on a child sleeping in a cold room; making the fire on a cold morning in an undressed condition; standing in an open doorway during cold or damp weather with head and shoulders insufficiently protected, to speak a few words to a friend who is too slow in taking his or her departure; stopping to speak to a friend on the sidewalk, long enough for the feet to become cold, and to experience a chilly sensation between the shoulders; making a call on a friend who receives company in a cold parlor, or in one in which the fire is started on your entrance; receiving lessons or giving lessons on a piano in a cold room; seeing a friend out to the gate and standing there until warned of the impropriety of the act by a sneeze, or "cold streaks" going up and down the back. For the protection of those young folks who can not forego the pleasures of the "parting at the gate," I would advise their guardian to have a portable gate constructed and placed in a room adjoining the parlor.

COLDS TAKEN IN THE CARS.

In these days when travel by railroad is so very common, a few words to the patients on the best means to prevent taking colds in the cars will be useful.

For men, a light cap, one that will come over the ears, so as to serve as a night cap, will be desirable. In cold weather a woolen cap is best. This cap should be put on as soon as the car is entered. A loose blouse should take the place of the coat usually worn. Slippers must not be worn. If there is a draught in the car, face it, do not let it strike the back.

Have the bed made with its head toward the engine; the dust will then be driven to the foot, where it will do the least harm. Be sure to have a sufficient quantity of bed clothes to keep warm.

A soft, loose-knit, woolen hood is the best head wear for women; this should be worn at night also. It should be warmer in winter than in summer months. The corsets should be removed at night and a loose woolen wrapper worn for a night dress. The stocking supporters as well as every constricting band around the waist should be loosened.

Every adult should take from five to ten grains of quinine on going to bed. It will be well to rub the hands, feet, face and neck with a little vaseline at the same time.

MEDICINE.

AN EASY AND RELIABLE METHOD OF DEMONSTRATING THE TUBERCLE BACILLUS.—Take a perfectly clean No. 2 covering glass, and with a needle give it the thinnest possible coating of sputum, selecting the specimen from one of the little yellowish or cheesy looking specks with which tuberculous expectoration always abounds, and allow it to dry in the open air protected from dust, or in the oven of the water-bath. When thoroughly dry, catch it in the forceps and whip it quickly several times through the flame of a spirit lamp, to fix the albumen. If an unusually rich specimen of sputum should be found, and time cannot be taken to make more than one or two finished mounts, dozens of covering glasses may be coated, dried, and baked, and then laid away in a tightly stoppered bottle for future use.

Being ready for staining, they are handled as follows: Take of aniline oil $1\frac{1}{2}$ drachms, alcohol 3 drachms, mix thoroughly, and then add of distilled water 5 ounces and $6\frac{1}{2}$ drachms. The water should be added gradually, shaking the bottle with each addition, and after standing a few hours, a little of this aniline water should be filtered into a watch glass or small porcelain dish. To the water in the watch glass or dish add about a half drachm of Dr. Gibbes' *Double Stain**, drop in the covering glass, sputum side down, and set the watch glass or dish, covered with a bell-glass, in the oven of the water-bath and run up the heat to 100° Fah. Let it stand for several hours at this temperature, after which catch the covering glass with the forceps and wash and decolorize in alcohol until all decided stain has disappeared and the alcohol is uncolored by it. Stand the covering glass on its edge to drip for a few moments, and then immerse it for a few seconds in either a solution of aniline blue or Bismark brown, for second stain, after which wash thoroughly in distilled water, then dip it in alcohol, stand upon its edge to dry, and when perfectly dry put on a drop of balsam with xylol and fix on the slide.

As a *diagnostic means*, instead of decolorizing with alcohol, *acid alcohol* may be used, according to the following formula: Nitric acid,

*Having had no success with this stain when used according to the directions given with each bottle, I concluded to try it with aniline water, as above described, and, to my great satisfaction, found it better, because more reliable, than any other method I have employed. The dilution for use with sputum on covering glass is about one part of the stain to six parts of aniline water; for section staining, one part to four parts.

10 drachms; distilled water, 15 drachms; alcohol, 95 per cent. 25 drachms; mix. After washing and decolorizing with the acid alcohol, the covering glass should be well washed in water, then in alcohol, dried, and further handled as above directed. By this method I have made hundreds of the best mounts of the tubercle-bacillus I have yet seen, and, therefore, can confidently recommend it to others.

When I wish to stain or demonstrate the bacillus in section from the paraffin cast, a section is made and fixed directly on the slide, according to the method first described in these pages; and, after passing it through turpentine or benzole and alcohol, and when ready for the stain, it is laid across a watch-glass full of the aniline water and stain, with the section side down, and kept thus bathed for fifteen or twenty minutes, at a temperature never above 110° Fah.; or the slide may be put into a beaker containing such mixture of aniline water and stain, and remain immersed for a half-hour at a temperature of 100° Fah.; after which it may either be washed and decolorized in the acid alcohol or in unmixed alcohol; but in either case it must next be passed through distilled water, to be prepared for the second or contrast stain (blue or brown), then further handled in the same manner as a covering glass with sputum mount. This method will show more bacilli than any other I have employed, or with which I am familiar.—Dr. Jas. E. Reeves, in *How to Work With the Microtome*; Bausch & Lomb, Rochester, N. Y.; price 50 cents.

WHAT ARE WE COMING TO?—Science—not satisfied with overturning our old ideas of theology, of miracles, and of the immediate intervention of some divine being, and taking from us the truthfulness of the marvelous stories of our childhood—must still pursue its iconoclastic labor, and interfere with our daily life. It has taught us that the substances we eat and drink, the air we breathe, are not in any instance just what we have always believed them to be; that, in fact, “things are not what they seem.” It has proved that the air is loaded with microbes, each one capable of producing millions of progeny, ready to pounce upon our vitals, except they were eaten by millions of others stored in the interior of our bodies.

It has proved that scarcely one of the many articles in common use, and considered nutritious, contains any of the substances we think it does. In England, more than half of the coffee consists of the livers of cattle baked to dryness and flavored; while in this country it consists largely of

beans, peas, and chicory. If one is *very* particular, and buys the whole bean, roasting and grinding for himself, he will find on analysis that the bean is paste, made by machinery.

An excellent article of black or green tea, which is guaranteed pure and for which a good price is paid, will resolve itself into the leaves of the willow (*Salix Latifolia*). A chemist of Chicago conceived the happy idea of converting corn starch (*a carbohydrate*) into sugar, (another of the series,) by adding to the one the element it needed, and lo, glucose was the product. Now, one pound of cane sugar at seven cents, and two pounds of glucose at two cents, makes three pounds of sugar costing eleven cents, but which sell at twenty-one cents.

Two hundred barrels of cider vinegar were confiscated at New York lately, because analysis showed that it was made by adding one pint of sulphuric acid at three cents, to forty gallons of water, and colored brown with burnt sugar.

It is not generally known that honey comb is made from stearine by machinery, filled with glucose, and sold as "honey in the comb;" nor that cream of tartar is made from starch and gypsum, with a little tartaric acid.

Only lately have we known that cows are not necessary for the production of milk. We can get just as good apparent milk, with cream too, from a mixture of salts and water. San Francisco learned this fact a few months ago, and New York has just received the proprietor of the compound.

The apple sauce which was, and is, so palatable, among the known ones, is only stewed pumpkin, or squash, with glucose, or molasses, and the same products of the soil furnish, with gelatine (from fish), nearly all our jellies and preserves; even our flour must receive its due amount of alum, in order that it shall make white, good looking bread from a poor quality. The fact that butter is made from refuse fats, and is impossible to easily distinguish from the genuine article, is as well known as its names, butterine or oleomargarine.

To say that the silk dresses of our wives are loaded with tin to make them "stand alone," or that the muslin is fixed with starch to make a glossy, fine appearance, is outside our province. Even our luxuries are beyond our comprehension.

The infant mind (and the adult too) looks "with anxious yearning" at the display of sweets in the confectioner's window. If they knew that the discovery of the new body "saccharine," *a product of coal tar*,

three hundred times sweeter than sugar, mixed with starch and terra alba, would represent all the sugar candy, would they buy it so eagerly? Yes! The saccharine costs \$12 a pound, but a teaspoonful in a bucket of water makes a liquid as sweet as sugar. Add starch and terra alba, with coloring matter, and flavor, and you have sugar candies.

The modern dude, by some self denial, has acquired money enough to take the object of his adoration for an evening out. Fortunately for him, *he* knows nothing of science or religion. He has his divinity with him, and is going to have ice cream and oysters. *She* knows nothing of microbes, or of modern thought (adulterations we say nothing about). The ice cream contains the deadly *tyrotoxin*, and by and by the nausea, vomiting and colic seize them both—and a doctor's bill is the consequence. If they happen upon a "pure milk" cream, the oyster, which has been lately denounced as "the scavenger of the mud flat," and in whose liver reside the "microbes of fearful disaster," is sure to produce trouble. A night of unrest, and dyspepsia follows, and he seeks the barber in the morning, that he may have his head rubbed and oiled. He does not know that in the brush reposes the microbe of *alopecia areata*, from some other head, that will fasten on his, and leave it as bare as a billiard ball. He needs a glass of whiskey to strengthen his nerves. That compound of methylic alcohol and oil of corn, produces such disturbance in the gastric membrane that a thirst is the result—a glass of beer will be the proper thing. If he thinks for a moment that the beer is only fermented barley and wheat, strengthened with *nux vomica* and alcohol, he would hardly try it; *he don't know*, and down it goes to produce lethargy and confusion of ideas. He will have a light breakfast, and asks for a cup of coffee, toast, and fresh eggs. Alas, he is ignorant that the hen whose product he is eating, may have been sick, while yet the egg was in embryo, and in its interior was planted the microbe, which will produce disturbance, and he is consuming an "inflamed egg," whose occupant may find a lodging in his liver! Truly, "Life is but an empty dream."

We go into the mountain to inhale the pure air, and drink the pure water from the flowing brook. No microbial milk; no inflamed eggs here. We happen upon a report of the United States Geologist, stationed at Pike's Peak, which shows us the analysis of the "pure snow," and water of the "icy fountains." *Here* is the source of the "mountain fever." The snow has caught the floating microbe in the air, and dissolving, carries it down in the pure (?) mountain water, to the dwellers along its course, and mountain fever results. We return to the city, dis-

heartened. Surely beef, mutton, and pork, the shibboleth of the restaurant waiter, and the basis of life, must be free from the universal enemy—no adulteration here.

We visit the market on Saturday—what rows of pure, fresh, glistening quarters of beef. What splendid exhibit of lamb and mutton, with fancy devices cut in the platysma myoides; what rolls of fat in the pelvic cavity. The very tails are appetizing; and the veal! What shall we say? We are tempted to eat it raw; and the hare, and rabbits. How many a chicken stew and pie will be served from them? And why not? Who can tell the difference? Ah! there is something in life yet—though milk deceives us, and eggs are dangerous; though ice cream and oysters distort our bowels, still there is the satisfaction that they are luxuries. Our thoughts wander far back into primitive life, when only the product of the chase was the food for the human race, and as we stand dreaming before a rich quarter of beef, our eye rests on a purple spot in the flesh. We make a gash in the spot, and out rushes a teaspoonful of pus. Not one of these beautiful beeves but has its abscess. Septicemia is not good to eat. Surely the tender calf, the infant beef, fed on milk. Ah! no milk from diseased cows! away with veal.

And we recollect with disgust and quailing of the stomach, the many reports of the health office, of immature veal “ultimately ripped (like Macbeth) from his mother’s womb,” and whose cellular tissue blown up with a quill, by the heartless butcher, proves seductive to the unwary housewife, and remunerative to the family physician. Pork, though very seductive in its infant stage, yet has a bad reputation for measles and trichina, and we discover that all our affections are placed on the young lamb, and its affectionate dam. We picture them sporting in the fresh green pastures, and thence innocently led to the slaughter “opening not their mouths.” We order a quarter for our Sunday dinner, and since we are assured by the discoveries of Kock, that that wide-spread, desolating scourge of the human race, may possibly find its origin in chickens—we refer to the bacillus of consumption—we content ourselves with a beautiful hare, that we may not miss our accustomed stewed chicken. Seekers after truth, and feeling that our feet rest on firm foundations, we study the history of the hare. Alas! we find that it is the favorite and universal habitat of the *Bothriocephalus latus*, the tape worm, and that not one is exempt. We must give *that* to the cat, and we look at each other in fear, lest further investigation should deprive us of every morsel of food. We draw the line at the hare, and resolve to look no further into the mysteries

of human subsistence, but trust to the care of a kind nature, who certainly provides against the effects of unscrupulous greed and human ignorance.—*Pacific Record*.

THE ANTIPYRETIC TREATMENT.—We may prove to be a medical Wiggins, but we predict that the pendulum of the antipyretic clock, which has ticked with such monotonous regularity, is about to take a swing to the other extreme. The impetus given to it, in late years, by the positive teachings of Liebermeister and others of the German school, has recently received a decided check from counter statements as regards the value of the antipyretic treatment, particularly that of typhoid fever, which have been made by many eminent practitioners of the same school, who have been reinforced by several careful and original investigators in America and England. In Italy and France, also, it would seem that the profession are by no means a unit as to the essential employment of this method of treating pyrexia. Of course, we allude especially to the exhibition of internal antipyretics during the febrile condition.

Bearing upon this important subject, we desire to call attention to the letter of Dr. Caldwell, dated Vienna, August 16, 1886, and published in the *Medical Record* of October 9, 1886. The remarks of Dr. Caldwell, we think, ought to have wide dissemination, in view of the prevailing belief—which has assumed the phase of a religious dogma—that a case of fever which had not been treated on the antipyretic plan, and proves fatal, has been sacrificed, either to the willful neglect, or culpable ignorance, of the practitioner who attended it. We apprehend that in the treatment of the continued fevers the shibboleth with many in the profession has too often been “Sine thermometro nulla therapia,” which may justly be echoed by the fever (and drug) stricken patient in the line “Timeo medicos dona ferentes.”

Dr. Caldwell refers particularly to the practice of Prof. Nothangel, and to that of Dr. Gasch, his assistant, “one of the brightest teachers of clinical medicine in Europe.” Speaking of the use of antipyretics in general, in the treatment of abdominal typhus, Dr. Gasch uses this very strong language:

“During the time we used them here, not only was this disease not shortened in its duration (though we controlled the temperature of the patient), but, on the contrary, it ran a more protracted course, and convalescence was more likely to be complicated by the intervention of a hypostatic pneumonia, and other untoward symptoms that arise from a weakened heart.”

Now, what could be more radically revolutionary than this statement? Have we not been taught all along to believe, that the weak heart of typhoid fever, with its parenchymatous degeneration as well as that of all the tissues of the fever patient, was absolutely caused by the operation of an intense degree, or a protracted duration, of pyrexia? Liebermeister says, "It is a poor excuse for the physician whose patient dies during the third week of typhoid fever from sudden paralysis of the heart, to justify his hitherto expectant treatment with the declaration, that up to this time no alarming symptoms had appeared, and no indications for active interference had been present. If he had observed and known the significance of the temperature, he would have foreseen the evil, and might have prevented it." How could he have prevented it? Why, of course by the antipyretic treatment; and embracing all that the term implies.

Not less surprisingly unorthodox are the views of Dr. Weinstein on the action of thallin, which dictum may be taken—as indeed he distinctly asserts—to apply to antipyretics in general. Dr. Caldwell epitomizes from a series of articles which have appeared, from the pen of Dr. Weinstein, the following :

"He tried the remedy in croupous pneumonia, erysipelas, tuberculosis, acute rheumatism, and the puerperal processes.

"It was especially to test the virtues of the remedy in typhoid fever that the experiments were made, as Ehrlich and Laquer had lately published their views, putting forward the opinion that the remedy was a specific for this disease. He claims that the lessening of temperature is more imaginary than real, the error coming in this way :

"The agent acts by paralyzing the heat-producing center in the brain; that such paralysis acts most potently on the peripheral nerves, and hence though you may have a decided lowering of the *axillary* temperature, if you test the vagina or rectum you will find the temperature of these parts far less influenced.

"The cases of pneumonia treated did especially badly, and he leaves the impression on the reader's mind that two of the cases that died might have recovered under more favorable and rational management. *He winds up by saying that he believes that antipyretics should be stricken from our pharmacopeias.* He says :

"Observe the calm, easy quiet of your patient whom you have sponged or bathed in case of typhoid fever, as contrasting with his condition after you have lowered his temperature by giving either thallin,

antipyrin, kairin, resorcin, and the like. In the last case you will be likely to see him with an anxious look, bathed with a cold sweat, and perhaps have to give him stimulants to prevent an impending collapse.' "

We acknowledge to having a chill of disappointment when we read the closing remarks of Dr. Caldwell which relate to the treatment of puerperal fever by antipyrin, a drug from which we were led, *a priori*, to expect the best results. Quinine, which in this formidable malady we have employed to combat the hyperpyrexia, has not yielded the satisfaction which would justify us in saying much in its favor; and we were ready to exclaim Eureka! when we had successfully used antipyrin in other febrile conditions which seemed to threaten the life of the patient, because of the exalted temperature. However, there are other obvious considerations which present themselves, in cases of childbed fever, that militate against a preconceived opinion that antipyrin, or indeed any antipyretic, could effect the good in this condition, which perhaps we have been ready to concede to its employment. Dr. Caldwell concludes his letter by referring to this point. He says:

" Prof. Briesky, after a fair trial, condemns in most positive terms the use of antipyrin in childbed fever. The case of Dr. Chase, cited in the *Medical Record*, can only be explained on the supposition that his patient had some peculiar idiosyncrasy that is certainly very uncommon, but in this case causing the antipyrin to act as a hypnotic. I have used the remedy in my own practice extensively, in most forms of diseases that have fallen under my observation, and which are accompanied by a high temperature. The remedy in my hands has never appeared to act as a curative agent, and has often been followed, even when given in moderate doses, by such unpleasant symptoms as to oblige me to discontinue its use."

RECTAL MEDICATION AND ALIMENTATION.—That the rectum possesses no mean powers of absorption has long since been established; yet its great importance is not generally recognized, and insufficient attention has been given to the many advantages of rectal medication and alimentation.

Medication by rectal suppository or capsule is simple, direct, and cleanly, and when indicated remedies are properly selected and prepared is very efficacious. The advantages of this mode are obvious: the stomach is left free for food, the disgust produced by nauseous medicines, their probable rejection by the stomach, the troubles of administering to chil-

dren and delirious patients, and many other practical difficulties, are all obviated.

Rectal alimentation also deserves more practical attention than it has hitherto received. Although the practice has obtained from the earliest period, and is probable as old as the science of medicine, yet we have not availed ourselves of its great utility, to the extent which its importance merits. Herodotus states the Egyptians used clysters at certain times for their health, and the ancient Greeks injected wine, whey, milk, ptisan, broth of spelt, etc., for this purpose. The Romans availed themselves of this method of administering nourishment, as a sustaining treatment, as well as most other civilized nations of which we have any record. The practice has continued to ebb and flow, with the fashion of the period, down to the present day. Many prominent physicians of the last and present century have strongly advocated its utility, and urged its more frequent adoption by the profession. The use of pancreatized enemata has been known for over two hundred years. It is mentioned in a Latin treatise published in 1671.

Now that science has furnished us with the means of supplying food partially if not wholly digested, and prepared for absorption, rectal alimentation should attain better results than in former days, and should be more frequently resorted to, if we would avail ourselves of every means in the interest of our patient. Pancreatized and peptonized aliment, in liquid or semi-liquid form, is readily absorbed by the rectum, and will sustain life for an indefinite period. Its utility in the large majority of diseases is so obvious that enumeration would be superfluous.—*Pacific Record*.

A DEFINITION OF GOUT.—Dr. Milner Fothergill gives the following succinct account of the pathology of gout: "When kidneys first appear in the animal kingdom, the form of urinary secretion is uric acid. Uric acid belongs to animals with a three-chambered heart and a solid urine (reptiles and birds). The mammalia possess a four-chambered heart and fluid urine, the form of urinary secretion being the soluble urea. When the human liver becomes depraved or degraded, it has a tendency to form primitive urinary products. To the question, "What is gout?" the answer is: "Gout is hepatic reversion, when primitive urine is formed by a mammalian liver."

A SOLVENT FOR SORDES.—Dr. A. D. MacGregor speaks highly of boric acid as a topical application in the unhealthy condition in which we frequently find the mouth, tongue, and teeth in severe cases of typhoid

fever. He says, in the *British Medical Journal*: The mouth is hot; the lips dry, cracked, and glued to the sordes-covered teeth by inspissated mucus and saliva; the tongue dry, or even glazed and hard, brown or black, crusted with a fetid fur. Under these circumstances a pigment containing boric acid (30 grains), chlorate of potassium (20 grains), lemon juice (5 fluidrachms), and glycerine (3 fluidrachms), yields very comforting results. When the teeth are well rubbed with this, the sordes quickly and easily becomes detached; little harm will follow from the acid present. The boric acid attacks the masses of bacilli and bacteria, the chlorate of potassium cools and soothes the mucous membrane, the glycerine and lemon-juice moisten the parts and aid the salivary secretion.

THYMOL AS A TENIAFUGE.—Dr. Numa Campi records as follows his experience in the use of thymol, or thymic acid, as a teniafuge:

In the evening I ordered 3 v of castor oil to be taken fasting; in the morning I prescribed 3 ij of thymol, divided into twelve doses, one to be taken every quarter of an hour; twenty minutes after the last dose had been swallowed, another 3 v of castor oil was taken. A few minutes after, a tenia medio-canellata 12 feet in length was evacuated, the head being dead. It is very important during the administration of the thymic acid, to give the patient some cordial and stimulant; cognac, or rum, will be found suitable. Thymol is very depressing, and this will explain its action on the nervous system. Even with small doses, the pulse becomes small and frequent, the respiratory movements slow, and the temperature is lowered. These effects, however, are easily and promptly counteracted by the use of stimulants.

The use of thymol is advocated for the following reasons: 1. Because this remedy, with the exception of a depressing effect, easily counteracted, produces no disturbance of the stomach or intestines. 2. On account of the rapidity and simplicity of its action, compared with other remedies, which require *courses of treatment*, divided into three periods, the preparatory, the expulsive, and the consecutive. 3. On account of the advantages it offers of being both a teniacide, and a teniafuge. 4. Because in case of an error of diagnosis the remedy would produce an efficient purgation and disinfection of the alimentary canal.

PROPHYLAXIS OF COOK'S CONJUNCTIVITIS. (Dr. G. C. Simmons, of Sacramento, Cal., in *Boston Med. and Surg. Jour.*)—A Chinese cook in our employ had suffered repeatedly from attacks of conjunctivitis owing to his labors over a hot cook-stove. These were soon cured by the use of

collyria of borax and camphor, and a caution as to the real cause. But only to return To our surprise, not long ago he appeared in large Chinese spectacles—tortoise-shell rims and plates of mica, transparent and non-magnifying. With these he goes happily to his work, and so far with no fear of a return of the conjunctivitis, and reasonably, too, as mica is notably a protector against heat. Consulting standard works on ophthalmology I find no reference to their use in occupations exposing one to conjunctivitis from heat, and the idea is certainly worthy of our remembrance.—*Phil. Med. News.*

“A HOMELY COUGH MIXTURE.”—I have not for the past five years found a cough among my patients, no matter what the age or what the cause, whether bronchial, laryngeal, pneumonic, tubercular or nervous, that did not receive more or less benefit from the free administration of a mixture prepared as follows:

One pint bottle of Nicholson's or Hoff's malt extract; whiskey (best), six ounces; glycerine (c. p.), six ounces; juice of six lemons; crushed sugar, two ounces. Mix and boil ten minutes. Dose from one to two tea-spoonfuls to one or two table-spoonfuls, according to age, every one, two or three hours as may be indicated.

Prepared in this manner we have a most excellent expectorant cough mixture for general domestic use, containing nothing to disturb digestion, no opium, no ipecac, as do most of the stereotyped cough mixtures in the shops. The glycerine and malt are both beneficial to nutrition, as well as expectorant; and the same may be said of all the component parts of the combination.

The amount of the lemon juice may be increased, according to the preference of the patient.—I. N. Love, in *Weekly Med. Review.*

PARALYSIS AGITANS WITHOUT SHAKING.—Dr. Beevor related several cases of paralysis agitans without tremor, in a paper read before the Medical Society of London. In these cases, fixed attitude, rigidity of the neck, with difficulty in looking up, expressionless countenance, slow delayed movements, difficulty is rising from the sitting posture, monotonous and mumbling speech, were present. The writing in nearly all the cases was wavy; retropulsion, apropulsion was frequently present. Charcot, Buzzard, and Gowers have published cases of this kind. It seems possible for paralysis agitans to run its course without any tremor being present.

TREATMENT OF THE URIC ACID DIATHESIS.—The correct treatment is, therefore, the alkaline treatment. For this purpose any alkali may be used, such as citrate or acetate of potassium. I prefer the citrate of potassium, in twenty-grain doses, four times a day, each time in eight ounces of water. Dilution is very important. It is of the greatest importance that you should, as it were, wash out the tissues of the patient with a tendency to gravel, in order to get rid of the *débris* of tissue metamorphosis. The introduction of large quantities of water into the system is an important element in the treatment. It is to the good effects of such treatment that the reputation of many of the mineral springs in the treatment of gravel is due. The introduction of plain water will accomplish this result as well as many of the spring waters. When, however, we come to springs like those of Vichy, which contain a large quantity of alkali, you can understand how useful they must be in the treatment of this form of calculus.—Dr. Tyson in *Boston Med. and Surg. Journal*.

INTRAVENOUS INJECTION OF SALT SOLUTIONS.—Dr. F. B. Harrington (*Boston Med. and Surg. Jour.*), after tabulating all the recorded cases of transfusion with salt solutions, recommends that the solution be made as follows :

Sodii chloridi.....	6 parts
Sodii bicarbonatis.....	I “
Aquæ destillatæ.....	1000 “

The solution should be warmed and kept at a temperature between 100° F. and 104° F. The solution should enter the circulation at a low pressure, and its effect on the heart should be carefully watched. Gravity pressure is safer than a syringe, an elevation of from one-half to three feet being sufficient. The amount used would depend upon the effect upon the circulation, but it may be from one to four pints.

VERY SIMPLE.—A classification of insanity is given by Dr. John P. Gray which for simplicity quite equals the famous classification of skin diseases into “eczema and not eczema.” It is as follows :

Mania, manifested by delusions of excitement, expansive ideas, exaggerations, self consequence, incoherence, etc.

Melancholia, manifested by delusions of depressing character, painful ideas and apprehensions.

Dementia, representing conditions of mental failure and feebleness of mental action.

All cases of insanity come under these three heads. Cases may be acute, sub acute, chronic, periodic, paroxysmal, but they are mania, melancholia or dementia.—*Med. Record*.

TO THE MEDICAL PROFESSION.

Dear Doctor:

For the past twenty-five years, "VIN MARIANI COCA" has been prescribed by the medical profession, and has invariably given uniformly good results. As a tonic and strengthener of the nervous system, with especial good effect on the respiratory and digestive organs, it is pronounced superior to any other adjuvant. Owing to the large demand for Vin Mariani, a number of imitations and substitutions are being enforced on patients [where physicians do not especially specify "VIN MARIANI"], and we would respectfully call your attention to this fact, as being the cause of the failure to secure good effects in many cases where Coca is prescribed. We thank you for kindly aiding us in our endeavors to popularize a truly useful and worthy medicament among the profession, and remain, at your service.

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THE DOSE of any of the Parvules will vary from one to four according to age, or the frequency of their administration. For instance, one Parvule every hour, or two every two hours, or three every three hours, and so on for adults. For children, one three times a day is the minimum dose.

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“ “ 20 “	5.00
Buggy “ 40 “	10.00.

ALOIN, PARV.....1-10 gr.

Med. prop.—A most desirable Cathartic.

The most useful application of these Parvules is in periodic irregularities—Dysmenorrhœa and Amenorrhœa. They should be given in doses of one or two every evening at and about the expected time.

DOSE.—4 to 6 at once. This number of Parvules, taken at any time, will be found to exert an easy, prompt, and ample Cathartic effect, unattended with nausea, and in all respects furnishing the most desirable aperient and cathartic preparation in use. For habitual constipation, they replace when taken in single parvules the various medicated waters, avoiding the quantity required by the latter as a dose, which fills the stomach and deranges the digestive organs.

CALOMEL, PARV.....1-20 gr.

Med. prop.—Alterative, Purgative.

DOSE.—1 to 2 every hour. Two Parvules of Calomel, taken every hour, until five or six doses are administered (which will comprise but half a grain), produce an activity of the liver which will be followed by bilious dejections and beneficial effects, that twenty grains of Blue Mass or ten grains of Calomel rarely cause, and sickness of the stomach does not usually follow.

PODOPHYLLINI, PARV.....1-40 gr.

Med. prop.—Cathartic, Cholagogue.

Two Parvules of Podophyllin, administered three times a day, will reestablish and regulate the peristaltic action and relieve habitual constipation, add tone to the liver, and invigorate the digestive functions.

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SURGERY.

CONDITIONS WHICH AGGRAVATE SYPHILIS.—Fornier (*Quarterly Compend. Medical Sciences*) maintains that certain physical conditions in the person infected have more to do with the gravity of syphilis than the quality of the syphilitic virus. These conditions he discusses as follows :

1. Alcoholism. A powerful factor in increasing the virulence of this affection, favoring the spreading and increasing the intensity of the cutaneous lesions ; producing severe symptoms, tertiary in character, early in the secondary stage ; creating special types of eruption, malignant, and involving large areas of skin surface, causing more frequent outbreaks of the syphilides, depressing the system, and finally predisposing to early nervous manifestations and causing deposits in the brain and spinal marrow.

2. Age. Syphilis is always severe at the two extremes of life. In the infant the disease, whether inherited, congenital, or acquired, is very frequently fatal, in striking contrast with its benignity in the child two, five or six years of age. In the adult it is usually mild. After fifty or fifty-five years the disease begins to be severe, and in old age it is extremely virulent.

3. Scrofula and tuberculosis act on syphilis and give rise to special symptoms, and at the same time syphilis exerts an unfavorable influence on those diseases. In those cases the syphilides have a moist, suppurating and fistulous character ; ocular, osseous, and articular lesions are frequently present ; and the larynx, pharynx, and nose are early and deeply involved. In scrofulous subjects a particular mixed kind of inflammation of the glands is noticed and in patients with tuberculous tendency pulmonary lesions are very often hastened.

4. Malaria also predisposes to grave forms of syphilis as seen in those affected with malarial toxemia.

5. All agents which depress the vital economy can serve as factors of virulence in syphilis such as extreme poverty, bad hygiene, insufficient alimentation, prolonged lactation, fatigue, mental worry, etc.

THE DIAGNOSIS OF RENAL CALCULUS.—(Dr. James Tyson, of the University of Pennsylvania, in *Boston Med. and Surg. Journal*.) If there is a history of excruciating pain in the region of the kidneys, extending into the groin, paroxysmal in character, a pain which is so severe that words cannot describe it, you at once suspect that there is a stone in the

kidney which is seeking to find its way into the bladder. I think that there is no condition which is likely to be confounded with this. Given a severe paroxysmal pain in the region of one or both kidneys, extending to the groin with retraction of the testicle in the male, I know of only one condition that can cause it. It is true that there is described in the books what is called neuralgia of the kidney, a condition in which there are symptoms described without the presence of a stone. For myself I doubt the existence of such a condition as idiopathic neuralgia of the kidney. What has been termed neuralgia of the kidney is in all probability nephritic colic, depending on the presence of gravel. For practical purposes, therefore, we may throw out of the question nephralgia, or neuralgia of the kidney.

It is also true that we have here severe muscular pains which might be confounded with pain in the kidney. The majority of persons who think that they have kidney disease, have their attention directed to it by the occurrence of pain in the lumbar muscles which they attribute to the kidney, the idea being that renal disease is associated with pain over the kidney. In point of fact, real kidney disease, other than calculous disease, is rarely attended with pain in the back. The pain of lumbago or rheumatism of the lumbar muscles is different from that due to impacted calculus. Under ordinary circumstances the former pain is not so sharp. It is true we have almost all experienced, at one time or another, a sharp lumbar pain, momentary in duration, most frequently coincident with a sudden motion or twisting of the body. But this is of short duration as compared with the pain of nephritic colic. The other lumbar pains of rheumatism are not so severe, although they may be of long duration. They are greatly aggravated by any movement of the body. They are also more readily removed.

There is one other rare condition which produces pain like that of nephritic colic, to which allusion should be made, and that is floating kidney. Sometimes a floating kidney is so loose that it twists upon itself, closing the ureter very much as a rubber-hose is obstructed when it is twisted upon itself. Such obstruction causes an accumulation of urine back of it, and gives rise to intense pain, which is quite like that of nephritic colic. This, therefore, should be remembered.

WARTS.—The *Medical Press* says: "It is fairly established that the common wart, which is so unsightly and often so proliferous on the hands and face, can be easily removed by small doses of sulphate of

magnesia taken internally. M. Colrat, of Lyons, has drawn attention to this extraordinary fact. Several children treated with three-grain doses of Epsom salts, morning and evening, were promptly cured. M. Aubert cites the case of a woman whose face was disfigured by these excrescences and who was cured in a month by a drachm and a half of magnesia taken daily. Another medical man reports a case of very large warts which disappeared in a fortnight from the daily administration of ten grains of the salts."

The following formula, a modification of that recommended by M. Vigier for corns, is largely used by Vidal for warts:

R. Acid, salicylic,.....1 gramme.
 Alcohol, 90°.....1 "
 Ether.....2½ "
 Collodion.....5 "

M. The solution should be painted over the affected surface each day.

TREATMENT OF HEMORRHOIDS BY INJECTIONS OF CARBOLIC ACID.—
 (Dr. Charles B. Kelsey, in *N. Y. Medical Journal*.) As far as I have been able to reduce this treatment to matter of rule the results are as follows:

1. Use only the purest crystallized carbolic acid, the purest glycerine, and distilled water in the preparation of the solutions. Each, when prepared, should be perfectly colorless and clear, the acid being in perfect solution. The glycerine is added to the solution of carbolic acid in water in just sufficient quantity to make a clear fluid, and the amount is not important. As soon as a solution begins to assume a yellowish tint it should be replaced by a fresh one.

2. Use only the finest and most perfect hypodermic needles and a perfectly working, and clean syringe with side-handles. After each injection when the syringe is put away, clean it thoroughly, to be ready for the next time.

3. The treatment may be applied to every variety of internal hemorrhoides, no matter what their size. It is not applicable to external hemorrhoids, either of the cutaneous or the vascular variety, both of which may be treated by better means.

4. Before making an application give an enema of hot water, and let the patient strain the tumors as much into view as possible. Then select the largest and deposit five drops of the solution as near the center of the tumor as possible, taking care not to go too deep so as to perforate

the wall of the rectum and inject the surrounding cellular tissue. The needle should be entered at the most prominent part of the tumor. If the hemorrhoid does not protrude from the anus, a tenaculum may be used to draw it into view. After the injection has been made the parts should be replaced, and the patient kept under observation for a few minutes to see that there is no unusual pain. The injection will cause some immediate smarting if it is made near the verge of the anus; if made above the external sphincter, the patient may not feel the puncture or the injection for several minutes, when a sense of pressure and smarting will be appreciated. In some cases no pain will be felt for half an hour, but then there will be considerable soreness, subsiding after a few hours. If it increases, instead of disappearing, and on the following day there is considerable suffering, which may not perhaps be sufficient to keep the patient on his back, but is still enough to make him decidedly uncomfortable, it is a pretty good indication that a slough is about to form. For the reason that it is impossible to tell absolutely what the effect of an injection is to be until at least twenty-four hours have passed, it is better to make but one at a visit and to wait until the full effect of each one is seen before making another. If, on the second day, there is no pain or soreness, another tumor may be attacked, and this will often be the case.

5. The strength of the solution must be regulated by the nature of the case, and in my own practice varies from five per cent. to pure crystallized acid. In a large, vascular, prolapsing tumor, which is well defined and somewhat pedunculated, five drops of pure acid may be used with the expectation of producing a circumscribed slough which will result in a radical cure. A thirty-three per cent. solution under the same conditions, will probably produce consolidation and shrinkage without a slough, but the injections will have to be repeated several times. A small tumor which protrudes but slightly, is not pedunculated, and can be seen and felt as a mere prominence on the mucous membrane, may be cured by a single injection of a five-per-cent. solution, which will cause it to become hard, and decidedly reduce its size, while an injection of fifty per cent solution might made considerable trouble, the remedy being too powerful for the disease. Guided by this principle, some experience will soon determine the choice of the solution. There is no arbitrary rule which can be applied to every case. As in any other surgical operation, some cases will be more satisfactory than others, and an occasional accident must be expected; but, on the whole, it seems to be the best method of treatment yet devised.

POINTS IN MINOR SURGERY AT THE PENNSYLVANIA HOSPITAL.—(Thomas S. K. Morton, M. D., in *Med. News*.) Shock is combated usually by warmth and stimulants. The former is applied by means of hot baths or water bags, generally the latter. The patient is surrounded by rubber bags filled with hot water. These we have had made for the purpose. They are round, from one and a half to two and a half feet long, from four to six inches in diameter, and have a filling-hole with a screw cap at one end, and a handle at the other. Atropia is freely used. Whiskey, ether, digitalis, aromatic spirits of ammonia, or, in desperate cases, aqua ammonia itself, are given. The injection of pure ammonia is, of course, always followed by local sloughing. Mustard, hot fomentations, large enemata, and drinks of warm fluids do good service. Previously warmed blankets are a great comfort as well as of benefit.

Ether is our standard anesthetic, although the A.-C.-E. mixture is often employed; chloroform very seldom. A small amount of the latter is found useful to relax the muscular spasm which often remains in drunkards, even when ether is fully pushed. A few drops will often permanently stop it, when the ether can be continued. A.-C.-E. has given rise to no alarming symptoms in at least two hundred administrations from my hands, and I know of no untoward circumstance attending its use here. All general anesthetics are administered from small, square-folded, very absorbent towels. The patent ink-bottle stopper is found convenient to pour ether from the bottle.

During the local anesthetic action of cocaine, we have performed many minor amputations, circumcisions, and other small operations; but with us, at least, the field of the drug in this direction is becoming quite limited. Most eye operations, however, are performed under its influence.

Divided or torn muscles, tendons, and nerves, if their ends can be seen, are sutured with catgut. If not visible, they are freely cut for, and likewise sutured. Good function is the most invariable result.

In the amputation of fingers and toes below the metacarpal or tarso-phalangeal joints, rubber umbrella rings are used as tourniquets. The flaps are closely stitched, and, if there be any bleeding when the ring is taken off, a deep lateral stitch back of the line of incision on one or both sides will always effectually control it. We never put a ligature upon these arteries, finding the above method amply secure, and, so far as our last few hundred such amputations show, unattended with disadvantage.

In exarticulations at the metacarpal or tarso-phalangeal joints no liga-

tures are applied if possible, but if the bleeding is obstinate, a deep stitch into the palm or sole can be made to control the appropriate vessel. These operations receive the usual house dressing and a palmar splint. They are, as a rule, not dressed from ten days to two weeks, when solid and complete union is expected and usually found.

Catgut sutures are passed through finger and toe-nails, without fear, if by so doing crushed or cut parts can better be brought into shape, and also in operations for ingrowing nails.

Abrasions and brush burns are carefully cleansed and treated with boracic acid ointment. Our receipt is : boracic acid and yellow wax, each one part, cosmoline, four parts.

Ligatures are never applied except in the largest operative and accidental wounds. Sutures run under or through the bleeding points effectually control them. No trouble is experienced in tying catgut sutures or ligatures, when the first tie of the knot is made as for a surgeon's knot. Catgut is invariably used for these purposes. In treating some hundreds of scalp wounds, no matter how extensive, I have never applied a ligature, always finding that carefully placed sutures will stop all hemorrhage.

Stitches are placed very close together in all wounds ; this presupposes proper drainage if it is necessary. If so, it is secured with a few strands of finest catgut, placed along the bottom, and brought out at one end of the wound.

Small or superficial wounds as rarely require drainage as ligature. Scalp wounds are not drained unless extensive. If the edges are much contused or torn, they are excised. Quite small wounds of the scalp or elsewhere, and sometimes larger ones, are, after antiseptic closure, covered in with a minute pad of bichloride cotton, and plastered down with either pure collodion or combinations of it with such drugs as evaporated tincture of benzoin (evap. fl. ʒij tr. benz. comp. to fl. ʒij, and make to fl. ʒij with collodion), iodoform (10 per cent.), salicylic acid, etc. Wounds too small for stitches are similarly treated.

Very tense hematmata are freely incised, the clot or fluid blood curritted out, any bleeding vessel stitched or tied if it can easily be found, and the whole sewn up with or without a drain, according to size, and dressed with some compression. Slowly resolving hematmata or those in which suppuration is present or incipient, are manipulated in exactly the same way.

Punctured wounds are laid open, curetted, washed with 1 : 1000

HgCl₂ solution, and closed as above. If the bottom cannot be reached, a small drain should be carried as deep as possible, and the best hoped for.

Gunshot wounds are treated in much the same manner. If it can readily be done, the ball is extracted through the wound or by counter-opening. The entrance and exit (if there be one) wounds are incised, the track of the ball curetted thoroughly, a small gut drain carried all the way through, and the external wounds treated as simple incised ones.

Compound fractures, if the skin wound is small, are freely cut into, washed with 1 : 1000, curetted, accurately stitched, and, if extensive, drained with catgut. Some of them are dressed more frequently than the actual wounds require in order that good position of the bones may be secured.

Wounds of joints are treated in precisely the same manner, save that, unless they are dirty, we are satisfied with thorough washing with 1 : 1000, and omit the curette. Cure in one dressing is here attempted and good function expected.

Poisoned wounds are also treated somewhat similarly, but the utmost care is taken to get to the bottom of the wound itself and into all ramifications and sinuses with the curette and strong antiseptic solution (1 : 500). If the wound is very bad and cellulitis present or threatening, continuous antiseptic irrigation (1 : 2000) is started as soon as the cleaning out is effected. Large glass percolating jars, with glass stop cocks, or other regulating device, suspended over the part give best satisfaction. Whilst thus employing irrigation any wounds should be well covered with protective, the whole part covered with lint, and the solution allowed to drip upon it.

Suppurating wounds might be classed as poison wounds, for the treatment is almost the same, namely : curette and antiseptic solution (1 : 1000 or 1 : 500), excision of wound edges and, usually, accurate approximation, with or without a drain, as circumstances indicate. Punctured, gunshot, suppurating, poison, and compound bone and joint wounds when thus dealt with, as a rule, heal by primary intention and under but one dressing.

Felons, buboes, simple and suppurating cysts, inflamed bursæ, and large, small, and diffused eradicable abscesses, are treated by exactly the same method, and usually with like result. Ineradicable abscesses, such as the psoas, are treated by this method as far as it can be made to go, and are then drained into an antiseptic dressing by means of a rubber

drainage tube; through which they are from time to time washed out with antiseptic solution. Care must be taken in so doing, however, whether it be these or other cavities, not to let any of the solution remain in. It should be displaced by a weaker solution or distilled water.

Burns, if small in area, or confined to an extremity, are treated by the regular antiseptic dressing. All easily removed dead skin, etc., is taken away; the parts washed with 1 : 1000 bichloride solution, or iodoform sprinkled on (in part for its analgesic effect,) then protective in narrow strips, and the dressing and cotton. Anesthesia may be required to do this properly. Extensive burns are covered in with boracic acid or oxide of zinc ointment, the surface of which is sprinkled with iodoform and, if there is much pain, smeared thinly with oleate of morphia. This dressing is covered in with cotton batting and a bandage or binder.

Just here it may be well to speak of sloughs, granulations, and skin-grafting, but what is said applies to all wounds as well as burns. Under the antiseptic dressing, sloughs are very slowly thrown off. It is our custom to excise them as soon as they become demarked. If properly done this causes scarcely any pain or bleeding and places the wound days, and, perhaps, weeks nearer closure. By picking up the edge of the slough with a pair of forceps, and cutting with knife or scissors through its readily apparent junction with healthy tissue, it is easily accomplished. By this same process I have successfully, and without pain or hemorrhage, amputated even fingers and toes which we had attempted to save.

All forms of exuberant granulations are usually shaved off with a sharp knife. The moist bichloride dressing, applied without the intervention of protective, is found to produce ample stimulation, if such is indicated.

If skin-grafting becomes necessary, a patch of thin skin is selected and made aseptic, as is also the granulating surface, if it is not so already. Almost microscopic pieces of the cleansed skin are then cut out by means of a purified needle and a pair of scissors, and planted among the granulations. Narrow strips of protective are applied, and upon this is placed either the "house-dressing," or simply a pad of dry 1 : 1000 cotton. Any bichloride solution remaining about the parts should be washed off with distilled water before the grafts are cut and set, and strong solutions should not be used while the islets of epithelium are forming.

Leg ulcers, when small, are stimulated, if necessary, by scoring with a sharp knife, nitrate of silver stick, etc.; dusted with iodoform; accurately fitted with a piece of protective, and a gauze dressing put on

with a firm roller. If they are large, and have callous edges, these latter are trimmed off, the sore curetted, perhaps straps applied after the iodoform and protective, and then the same dressing. By this method they can always be kept perfectly sweet and clean; the discharge is but slight, and the pain still less. If the ulcers are very irritable, and will not bear the gauze dressing, boracic acid ointment is substituted for it.

Those painful, non-ulcerative conditions of the legs so often met with behave excellently under one or the other of the above dressings.

In regions where it is impossible to apply or retain a regular dressing, great pains are in taken the cleansing before and after an operation, and iodoform in conjunction with frequent corrosive sublimate irrigations is freely used afterward. Especially are these applications valuable about the genito-urinary organs and rectum. In females, after most operations thereabouts, the vagina is washed with 1 : 1000, and then *filled* with iodoform. Beyond an occasional irrigation of the external parts, nothing more need be done until the stitches—if they have not been of cat-gut—are ready for removal.

Chancroids heal wonderfully if kept buried in iodoform; sometimes they are previously brushed over with acid nitrate of mercury, etc. No treatment is directed to hard chancres unless complicated.

Body parasites are destroyed with 1 : 500 corrosive sublimate solution. No unpleasant effects have been known to follow even the freest use of the solution in this way. If the ear has been invaded, it is syringed with that solution, and then filled with oleate of morphia and a little wad of cotton put on top.

TAXIS.—As a result of a study of thirty-three herniotomies, Prof. P. S. Conner, of Cincinnati, speaks as follows of taxis and its relative dangers: Taxis, if it succeeds, accomplishes the desired purpose without exposing the patient to the risk of an open wound; but, if the return of the bowel is effected only after long-continued severe manipulation, dangerous and usually fatal inflammation may be the direct result of the violence done; the taxis having, instead of putting in order, sadly put out of order. Fortunately the bowel oftentimes recovers from the effects of much violence.* Sometimes, though no undue force has been employed in the reduction, a general peritonitis is soon developed by direct exten-

*Perhaps unfortunately, for, if it were true and thoroughly well understood that the exercise of other than gentle pressure would certainly rupture the intestine, there would be vastly less crowding and pushing and squeezing done than now, and the death-rate without, and especially with operation, would be greatly lessened.

sion from the previously nipped and already inflamed intestinal loop, such extension rarely taking place so long as the tight constriction remains. If the protracted, or repeated, or violent manipulation fails, and recourse must be had to the knife, the probabilities of a successful issue are greatly diminished by the delay and the local injury from undue pressure. What is proper taxis, as respects both time and force? It is impossible to say. Judgment and knowledge should in every instance direct and control the manipulation. One thing is certain, taking numbers of cases together, there is very much more danger in severe prolonged taxis than there is in herniotomy. So far as patients are concerned, it is better to cut too soon and too often than to delay too long in the hope that further and more forcible efforts may secure reduction. While it seems to me unwise to fix any arbitrary short limit, whether it be five minutes or half an hour, beyond which manipulations should never be prolonged—for what is right in one case and to one person may be altogether wrong in and to another,—yet I am not sure but that fewer lives would be lost than are now if it was the rule to operate at once on every case that was not speedily relieved by the efforts of the patient himself. No ruptured person is liable to damage himself seriously, though he may occasionally do so; but the same can not be said of the inexperienced practitioner, especially when working upon an anesthetized patient.

The more I see of hernia the more I am convinced that, if the protrusion does not go back readily and speedily, the best interests of the patient will be subserved by an early operation. If the constriction is outside the sac, and the lesser operation is all that is required, there is almost no risk in its performance, and a speedy recovery, often by first intention, may be expected. One of my patients on the ninth day walked a mile and had a truss fitted. If the sac must be opened, the danger is increased; but, under present methods of treatment, not greatly so. Of the fatal cases I have had, in but one was death due to the wound; and in that case it was tetanus, a rare complication, that interrupted what had been for more than ten days, and promised to continue to be, a steady progress toward recovery. So little is the danger now directly due to the opening of the sac, and so great is the risk of life if an ulcerated or dying knuckle is returned into the peritoneal cavity, that I believe it is the wisest course in all cases other than those of very short duration to expose and examine the constricted bowel or omentum; especially since, by including the stump of the sac in sutures passing through the margins of the external inguinal or femoral ring, early reprotrusion is prevented, and a radical cure of the hernia may often be effected.

MEANS FOR THE PREVENTION OF MYOPIA.—Priestly Smith, in an article on "Means for the Prevention of Myopia," enumerates the following essentials for a school desk:

(1) The seat must be of such a height as will allow the scholar's feet to rest flat on the floor or footboard, and broad enough to support the greater part of the thigh.

(2) The seat must have a back placed at such a height as to fit the hollow of the back below the shoulder-blades, and support the body in a vertical position.

(3) The near edge of the desk must be just so high above the seat that when the scholar sits square and upright, with the elbow to the sides, his hand and forearm may rest upon the desk without pushing up the shoulder.

(4) As used in writing the desk must have a slope of ten or fifteen degrees (about 1 in 5); as used in reading it must support the book at an angle of about forty-five degrees, and at a distance of at least twelve inches from the eyes—sixteen inches is better.

(5) As used in writing, the edge of the desk must overhang the edge of the seat by an inch or two, in order that the scholar shall not need to stoop forward, and that the support to the back may be maintained.

(6) Either the desk or the seat, or some part thereof, must be movable at pleasure, so that although the desk usually overhangs the seat, the scholar may be able at any time to stand upright in his place.

(7) The desks and seats must be of various sizes, in order that the foregoing conditions may hold good with scholars of various ages.—*Boston Medical and Surgical Journal*

CHROMIC ACID IN MUCOUS HYPERTROPHY.—M. Poskin has reported on his use of chromic acid in more than one hundred cases of diseases of the nose, pharynx, and larynx, as showing the great value of this powerful caustic in hypertrophy of the turbinated bones, polypi and granulations in the ears. He remarks that, as it is a violent poison, acting especially on the gastro-intestinal tract, it is necessary to exercise great caution, especially in pharyngeal and laryngeal cases; and he eschews it altogether in the case of children. Its action may be neutralized by a weak solution of carbonate of soda. The best way to employ chromic acid is to heat moderately a very small crystal on a silver probe, to which it will adhere as a dark-brown coating. If the heat is too great, a green oxide is formed, which is devoid of any caustic action. M.

Poskin finds that chromic acid compares favorably with the galvanocautery, both on account of the cost and the convenience with which it may be applied. It is, he thinks, also quite as efficacious and less dangerous. The eschar which is produced falls in from three to five days.—*Lancet*.

OBSTETRICS.

EXPLORATORY LAPAROTOMY.—Dr. T. Gaillard Thomas is a thorough believer in laparotomy for diagnostic purposes (*Phil. Med. News*). He says he would write on the walls of every hospital devoted to abdominal surgery, this legend: “When a doubt as to the diagnosis of an abdominal neoplasm of serious character or of certain obscure pathological conditions of the abdominal cavity which threaten life exists, give the patient the benefit of explorative incision.”

After an experience yielded by seven or eight hundred cases, approximately, of laparotomy for various causes, extending over a period of twenty-three years, he says he has never once regretted opening the abdomen, and that he has in a dozen cases, at least, deeply regretted having failed to do so. It is certain that in the future explorative abdominal incision will become the rule in all cases of the following conditions which do not yield to medical means, and concerning the etiology of which there is great doubt: first, wounds and injuries of the abdominal viscera; second, intestinal obstructions; third, the presence of stones in the gall-bladder or kidneys; fourth, the accumulation of blood, pus, or serous fluid from any cause; fifth, the existence of a neoplasm in any part of the abdomen; sixth, the occurrence of serious organic changes in certain of the viscera of the abdomen, such as the kidneys, the uterus, the Fallopian tubes, the ovaries, or the spleen; seventh, ectopic gestation.

It is a remarkable fact, and one which constantly excites the wonder of the uninitiated, how grave errors of diagnosis in reference to abdominal tumors are made by men of the largest experience, the maturest judgment, and a life long devotion to the work of gynecology. The truth is, that all over the world errors in diagnosis in the field of abdominal tumors are, and probably will forever be, common, unavoidable, and, except in rare cases, entirely excusable. He who declares that he does not frequently err, belongs to one of two classes: that of those who lack the intelligence to appreciate their shortcomings, or the courage to confess them, for it is only the good diagnostician who can afford to

own to diagnostic errors, or to that of those who, by *suppressio veri* or *suggestio falsi*, are short-sighted enough to hope to deceive the community which watches their careers.

It is for the purpose of avoiding such errors that explorative incision is peculiarly valuable. It may be that there is doubt as to whether a neoplasm is a fluid tumor of the ovary or a solid one of the uterus; or whether an abdominal dropsy is due to incurable hepatic disease, or to some tumor no larger than an apple, situated deep down in the pelvis; or as to the benign or malignant nature of some growth about which nothing positive can be settled. In such cases the results of opening the abdomen are most striking and gratifying; they beam upon the existing obscurity as the rays of an electric light upon previous darkness, and even although the result of the incision may serve to assure us merely that death will very soon close the scene, this certainly is better than the cruel uncertainty which previously existed, and the grief of relatives is assuaged by the feeling that "no stone has been left unturned" to procure a relief which science is powerless to bestow.

After giving a large number of illustrative cases, he gives the following:

Rules for explorative incision of the abdomen: 1st. Every explorative incision should be made under the strictest antiseptic precautions. As to strict cleanliness all are agreed; if antiseptics of chemical character are valueless, they at least, in all probability, do no harm; while the question as to their utility is "sub judice," give the patient "the benefit of the doubt," and employ them.

2d. Always employ an anesthetic, lest the complaints of the patient should frustrate the investigation, or at least render it superficial and uncertain.

3d. Always make an incision which will admit the whole hand; one which will admit two fingers only is hardly warrantable. If possible let but one man's hand be passed into the abdominal cavity; in a multitude of counsel, there is, in these cases, danger. The brain which guides the hand should be competent for deciding the question at issue.

4th. Never hurry an explorative incision, but never prolong one unnecessarily; let discussion as to diagnosis occur after the peritoneum is closed, not while it is open; and let the fact be appreciated that the clinical lecture, which is so common at this moment, is always a source of great danger.

THE ETIOLOGY OF SALPINGITIS.—Martin has reported the results of his observation in 287 cases of diseased Fallopian tubes. In over one half of the number the inflammation simply began in and extended directly from the uterus; of the other half, fifty per cent. were of puerperal origin, five sixths were due to gonorrheal infection, and one sixth to tuberculosis. The left tube was alone affected in 138 cases, the right in 58, and both in 91. Two forms of salpingitis are clearly distinguishable, *endosalpingitis interstitialis* and *endosalpingitis follicularis*; in the former variety the muscular coat of the tube is extensively involved, and eventually its peritoneal covering is affected, the epithelium and fibres being more or less destroyed; in the latter the entire wall is filled with numerous "follicular spaces," similar to those in the *portio vaginalis*. Secondary contraction of the inflamed parts results in the closure of the distal opening of the tube and the formation of characteristic sacculi. The entrance of micro-organisms (of puerperal sepsis, gonorrhea, tuberculosis, or actinomycosis) is followed by suppuration. There is no peculiar pain characteristic of tubal disease, nor is menorrhagia a constant symptom. The prognosis is not so gloomy as it has been represented; the inflammation may subside and a perfect cure follow, so that the patient subsequently becomes pregnant. If palliative treatment is unavailing, "*and the symptoms are very severe, an operation is justifiable.*" Martin has operated sixty-two times. [This paper is a most instructive one, representing as it does the unbiased opinions of a prominent gynecologist, who occupies a conservative position with regard to a question which has provoked a somewhat heated controversy. His calm, scientific manner of treating the subject can not fail to add force to the deductions which he draws from carefully observed anatomical facts.]—*N. Y. Med. Journal.*

RETROFLEXION OF THE UTERUS.—Vedeler, of Christiana (*Arch. f. Gynak.*) from observations in upward of three hundred cases, expresses a number of radical opinions, of which the following are the most important; Retroflexion is unattended by symptoms in forty per cent. of the cases; this applies to all degrees of displacement, and to every period in the life of a woman. Retroflexion may be produced experimentally without giving rise to symptoms. Moreover, the symptoms which were ascribed to the displacement often persist after the uterus has been restored to its normal position. Besides, a careful history of many cases will show that before the retroflexion occurred the patient complained of the same pain which was afterward attributed entirely to the displacement. Finally, retroflexion is a condition possessing a certain amount of anatomical interest, but it is of no significance from a pathological standpoint.—*N. Y. Med. Journal.*

COLUMBUS MEDICAL JOURNAL.

EDITORIAL.

Heating and Ventilating.

The connection of the heating of a house with its ventilation is, of course, inseparable. Many persons will cheerfully expend ten or fifteen thousand dollars in building a house, putting from two to three thousand on outside ornaments, who would not dream of spending five hundred or one thousand dollars for the necessary Hot Water Apparatus to keep this same house thoroughly and comfortably warmed and well ventilated.

In reading the reports from the various Boards of Health, one can not fail to notice the startling increase in the death rate from Scarlet Fever, Diphtheria, and allied diseases. It might safely be said that this condition of affairs is due to the fact that the tightly closed doors and windows, which cold weather makes necessary, prevents the ventilation of houses, which is essential to the maintenance of health.

To those who intend erecting a dwelling, we would advise that the matter of heating and ventilating be given much consideration; and before deciding how it shall be done, consult the A. A. Griffing Iron Co., Manufacturers of the Tompkins Hot Water Indirect Radiator, 518 Communipaw Ave., Jersey City, N. J.

Fluid Forms of Hydrastis.

The reputation of this drug as a therapeutic agent was first gained through its employment in the form of an *infusion*; and in the fifty years following its introduction into medical practice, a continuous effort has been made by manufacturers to perfect a preparation which would represent all the active principles of the drug, without the high price of the salts, either alone or in combination.

The most prejudiced writers on *Materia Medica*, accord to the late Wm. S. Merrell the largest share of credit in the introduction of Hydrastis preparations, and to the present organization the reputation of being the *largest consumers of the drug in the world*. For more than a half-century, Hydrastis has been made a study in our laboratory, and we do not think we exaggerate its importance when we assert that it stands pre-eminent to-day as the most valuable exponent of our vegetable *Materia Medica*.

The following preparations *in fluid form* are receiving our special attention at this time:

Fluid Hydrastis—MERRELL.

Is what its name implies—the active, medicinal principles of the drug in natural combination and in a fluid form. It has a bright, yellow color, perfectly clear, free from sediment, and with an unmistakable odor of the *fresh drug*.

Fluid Hydrastis is a pure, neutral solution of all the alkaloidal constituents of the drug, rejecting the oil, gums, irritating and offensive resins and inert extractive matters. The success attending its introduction is the best evidence of its therapeutic value.

Unsuccessful imitations and would-be substitutes are met with on every hand. Preparations said to be “just as good” or “about the same thing,” but always “a little cheaper,” attest the wide-spread and growing popularity of Fluid Hydrastis. All such, compared with the latter as to physical appearance or as representatives of the drug, *are condemned*; dispensed in prescriptions, *they are readily detected*; tested therapeutically, they are *promptly rejected* as unworthy of confidence.

Fluid Hydrastis is applicable to the treatment of all irritable, inflammatory and ulcerative conditions of the mucous tract.

This statement of a well-known medical writer and journalist has become axiomatic:

“No remedy for physician's use has been received with such universal approval.”

Solution Bismuth and Hydrastia—MERRELL.

An invaluable and scientific combination, wherein the beneficial action of the white alkaloid is increased by association with Bismuth. This solution contains $2\frac{1}{2}$ grains of the double Citrate Bismuth and Hydrastia; twenty-five per cent. of which is Hydrastia Citrate.

The cordial reception accorded this preparation marks it as the most valuable combination in the market in which the white alkaloid alone represents the valuable properties of the drug. Used in diseases of the nasal passages, of the eye, of the throat, of the stomach and intestines, of the reproductive organs and bladder it is equally beneficial.

Colorless Solution of Hydrastia—MERRELL.

This is a permanent solution of the white alkaloid, without the addition of any other medicinal agent to modify or increase its action. It is offered without special recommendation to meet the views of an unlimited number of physicians, with whom the color of the Fluid Hydrastis is an objection. This solution contains in one fluid pint the same proportionate strength of white alkaloid as exists in an average quality of crude root.

See notes above on Solution Bismuth and Hydrastia.

“Merrell's Hydrastis Preparations” are for sale by Wholesale Druggists throughout the United States. Please Specify “Wm. S. M. Chem. Co.” in ordering or prescribing.

THE WM. S. MERRELL CHEMICAL CO.,

CINCINNATI.

ORR, BROWN & PRICE and BRAUN & BRUCK, Columbus, Wholesale Agents.

EDITORIAL DEPARTMENT.

J. F. BALDWIN, M. D., Columbus, - - - - EDITOR.

Communications, reports, etc., are solicited from all quarters.

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HANN & ADAIR, Publishers, Columbus, O.

EXPERT FEES IN OHIO.—It seems likely that the question of special compensation for medical experts will soon be brought to an issue before the courts of Ohio, ultimately even before the Supreme Court itself. Dr. F. H. Darby, of Morrow, was recently summoned by the State as an expert in a murder case. He refused to answer the following question unless paid a fee of \$25: "State whether in wounds like this there would be immediate gaping, or would the lips of the wound for a time remain in contact or nearly so?"

For this refusal he was sent to jail for contempt. He was afterwards set at liberty, on his own recognizance, and we understand his case will be made a test one.

In reply to the question why he refused to answer, the doctor replied as follows:

"Because it is expert testimony. To render such requires a very liberal expenditure of time, labor and capital to acquire the knowledge necessary to give it. This knowledge is the physician's stock in trade; it is what he has to sell. For the State or anyone else to extort this from him without reasonable compensation, is unjust and in direct violation of every principle of law and equity. The duties of common witnesses, physicians, like the good citizens that they are, have ever been willing to assume. To matters of fact, we are willing to testify at any sacrifice. We feel that we owe it to the State that the ends of justice may be meted out to evil doers. Just as a jurymen in civil life makes a sacrifice of time, or the soldier, in times of war must take up arms in defense of his country, so too, we feel under a like obligation to abandon our respective fields of labor, many of which are quite remunerative, and if need be spend day after day in court to elucidate any facts that may have come

under our observation; but here we draw the line, and I, for one, take the position that questions of opinion, the correct answer to which depends on previous and special education, professional knowledge and skill, is our private property, and instead of the State being a party to our robbery it should extend to us the strong arm of protection, as it does to other property owners."

If, as we understand the case, the doctor was here as a pure expert, having no personal knowledge of the case whatever, the issue will be fairly presented. In some of the cases which have been decided in other States, the physician was a witness as to facts and refused to answer when questioned as to matters of opinion. In several such cases the Court has not sustained the physician, refusing to discriminate between a pure question of fact and an incidental one of theory. Such cases are inherently weak. But Dr. Darby's case is a strong one, and should be pushed.

Ohio has as yet no decision on this subject. In Franklin county, our courts have usually granted expert fees. In one case, a few years ago, the experts, who were all from the city, were allowed \$20 each. But, of late, the allowance has been fixed at \$5 a day; and, as several days are usually consumed after the day of the summons before the expert testimony is reached, this allowance will probably average about \$15—three day's fees for an actual attendance of only a few minutes.

Few States have any *law* on this subject. Iowa has the following:

"Witnesses called to testify only to an opinion founded on special study or experience in any branch of science, or to make scientific or professional examinations, and state the results thereof, shall receive additional compensation, to be fixed by the Court, with reference to the value of the time employed and the degree of learning or skill required."

Similar provisions exist in North Carolina, Rhode Island and Minnesota.

It is hardly fair to expect Dr. Darby to carry this test-case on alone. Every physician in the State is more or less interested in it. Dr. Darby is a member of our State Society, and we should all support him, both morally and financially. We hope that our readers will respond to the hint, and remit to the Doctor direct, or through the JOURNAL, which will take pleasure in acknowledging all receipts for this cause.

The *Pittsburgh Medical Review* is the title of a new monthly, edited by seven gentlemen of Pittsburgh, Pa., viz.: Drs. X. O. Werder, C. S. Shaw, J. J. Buchanan, A. Koenig, P. McCough, J. J. Green, and T. L. Hazzard. The first number is well printed and presents a promising appearance.

OHIO STATE SANITARY ASSOCIATION. The fourth annual meeting of the Association will be held in the Board of Trade Room, Columbus, Ohio, on Thursday and Friday, February 10th and 11th, 1887. The following papers are announced.

"The probable results of Sanitation one hundred years hence." D. J. Snyder, M. D., Scio.

"A Scientific Standard for the safety of illuminating oils." D. H. Beckwith, M. D., Member of the State Board of Health, Cleveland.

"The cause of deafness and blindness with special reference to the eruptive fevers." S. L. McCurdy, M. D., Surgeon for the Pennsylvania Co., Dennison.

"Cremation of the lower animals," E. S. Rickets, M. D., Portsmouth.

"Water Closets and Privy Vaults," John McCurdy, M. D., Youngstown.

"Injurious Gases," David O'Brine, M. D., Assistant Professor of Chemistry, Ohio State University.

"Our Fever Epidemic from Drinking Sewage." C. E. Kurz, M. D. Bellaire.

"The Sanitary Condition of Sandusky before and after the completion of Water Works and a Sewerage System." Elwood Stanley, M. D., U. S. Marine Hospital Service, Sandusky.

"The Plumber's role in the Sanitary Drama of the day," E. A. Futerer, Master Plumber, Columbus.

"Syphilis, from a Sanitary Standpoint," C. E. Beardsley, M. D., Ottawa.

"School Sanitation," Hon. LeRoy D. Brown, Ph. D., Ex-State School Commissioner, Hamilton.

"Some of the practical results of our Criminal Laws from a Sanitary Standpoint," R. Harvey Reed, M. D., Mansfield.

"Diagnostic Responsibility," H. M. Lash, M. D., Athens.

"The Results of a Mistaken Diagnosis and its Consequences in Loss of Life and Financial Paralysis," Thos. W. Gordon, M. D., Georgetown.

"Examination of Air of Apartments," Curtis C. Howard, M. A., Professor of Chemistry, Starling Medical College.

"Hygiene of the Sick Room," F. C. Larimore, M. D., Mt. Vernon.

"The Sanitary Condition of the City of Mexico from Personal Investigation," F. D. Shreve, C. E., Bucyrus.

"The Plumber's Plea for Representation on the State Board of Health," Wm. Halley, Master Plumber, Columbus.

"Ptomaines and Poisoning by Tainted Foods," J. U. Barnhill, B. S., M. D., Lecturer on Toxicology, Columbus Medical College.

"The Relation of Climatic Changes to certain Diseases, with Chart Illustrations," E. M. Mark, Sec'y Ohio Meteorological Bureau, Columbus.

"The Chronic Insane under County Care, and in the care of Families," F. H. Darby, M. D., Chairman of Sanitary Committee, Morrow.

Reduced rates have been secured on all lines centering in Columbus, and will be granted to all persons desiring to attend the meeting, who, on application to the Secretary, Dr. R. Harvey Reed, Mansfield, O., at least one week prior to the time of the meeting, will be furnished with the proper certificates, which must be secured before leaving home.

JEFFERSON MEDICAL COLLEGE.—The friends of Jefferson Medical College had begun to look with alarm at the decline of that worthy institution, and for some time have been endeavoring to ferret out the cause of the trouble. They have found that under the administration of Bartholow, the standard for graduation has been lowered. This led to the temporary black-listing of the institution by the West Virginia Board of Health. They found that under the administration of Bartholow, the institution had been placed in an attitude of antagonism toward the American Medical Association. This led to the withdrawal of all Jefferson men from the International Medical Congress. They found that under the administration of Bartholow, their institution more through the influence of his personal than official utterances was sectionalized. This resulted in the alienation of the Western and Southern supporters of the school. In fact, before they were through with the investigation they ascertained that this institution had been under suspicion from the very day that Bartholow was called (?) to the faculty.

It appears from recent developments that the Board of Trustees, the governing body of the institution, has at last taken the same view of the case. As a result the faculty is being or has been re-organized. We have the assurance, presumably *ex cathedra*, of the *Medical and Surgical Reporter* that the office of Dean has been abolished and the offices of President and Secretary have been established, Prof. J. M. DaCosta, having been called to the former and Prof. J. M. Holland, to the latter position. Prof. Bartholow, it is stated, has "resigned" the Deanship.

Jefferson Medical College is to be congratulated on the promptness with which it has thus, for cause, relegated its most prominent official to the ranks, and the emphasis with which it reasserted its position in the front rank of medical schools. It is next in order for the Board of Trustees to give attention to the fact that the Chair of Materia Medica and Therapeutic is occupied by the most conspicuous plagiarist in American medical literature.—*Cin. Med. Journal*, Oct, 15, 1886.

HYPERBOLE. An esteemed Texan exchange thus anticipates 1887:—

"We may feebly, therefore, forecast the policy of the ——— for the coming year. Brimful of energy, enterprise, and financial backing, the ——— will start, with an invigorated and undaunted spirit, on the future labors which are horoscoped in the new year that will soon dehisce, as it were, into the full glory of an actual, living reality."

If the above is "feebly" expressed, what would have happened had the editor been feeling first-rate?"

WE ARE glad to report the conviction of James Crosher, the notorious swindler, for imitating the well-known preparation of the Messrs. Wyeth's "Beef, Iron and Wine." He pleaded guilty before Judge Moore, of the Court of Sessions, Brooklyn, N. Y., and was sentenced to three months in the penitentiary and \$200 fine.

We think that the drug trade are to be congratulated upon the arrest, conviction and sentence of this man. Imitations and imitators are contemptible, and the only regret regarding this one, is that the sentence was for so short a period.

IT IS suggested that if a quantity of suspected phthisical sputa be placed in a conical glass, and kept at a temperature of about 100° for twenty-four hours, the heavier masses—those most likely to contain bacilli—will sink to the bottom and may then be secured for examination, either by decanting the upper portions or by a pipette. It is likely, also, that during this time there might occur a considerable culture of the bacilli.

THE many friends of Dr. X. C. Scott, of Cleveland, will regret to learn of the death of his wife, Edith Cole Scott, which occurred in the 30th year of her age, at Pasadena, Cal., on the 5th ult

DIED.—Dr. Alfred Ball, one of the ablest and most widely-known physicians of Zanesville, Ohio, died at his home in that city on the 6th ult.

REVIEWS AND BOOK NOTICES.

The Science and Art of Obstetrics. By Theophilus Parvin, M. D., LL.D., Professor of Obstetrics and Diseases of Women and Children, in Jefferson Medical College. With 214 wood-cuts and one colored plate. Philadelphia. Lea Bros. & Co. 1886. pp. 701.

Dr. Parvin's work on Obstetrics, long announced, has at last appeared, much to the gratification of his numerous friends, who can but congratulate him upon the completion of his book. A careful examination of the work enables us to say that the author has succeeded in presenting the subject in a clear and concise manner, and has presented to the profession an excellent work upon the important branch of medicine of which it treats. The subject is brought up to the times upon those important points where rapid progress is being made, as intra-uterine gestation, and those in regard to which the results of recent study have an important bearing upon practice, as the Cesarean section. We are glad to see a good many new illustrations, some of them such as to render important aid to the student.

One of the most difficult subjects connected with obstetric medicine, and as important as difficult, is puerperal fever. Dr. Parvin's treatment of this is eminently clear and satisfactory. There are points, it is true, to which we might demur. We are not quite ready, for instance, to abandon the autogenetic origin of the disease, so much in accord, etiologically, with surgical septicemia. Again, while fully assenting to the doctrine, that a puerperal patient having continuous fever, not dependent upon the nipple or breast, should be held to be suffering from septic infection, we are not prepared to accept the statement that malarial fever in child bed is not frequent; because it does not accord with our own experience, and we believe that it will not be assented to by the majority of practitioners in the West and Southwest.

We are glad to note that in the treatment of this affection the author advises intra-uterine injections. The proposed abandonment of these in some quarters, coincident with the growth and acceptance of either the septic or bacterial origin of the disease, seems most inconsistent and illogical.

In some respects the work might be criticised; in regard, for instance, to arrangement, relative amount devoted to certain subjects, etc. But these are minor matters, and dependent, some of them, much upon taste. As a whole, the book deserves much commendation. The author has

succeeded in doing that which the preface announces as his aim. He has presented "the most recent information relating to obstetrics, at the same time not overlooking important truths established by past experience." It is a good treatise for the student, and reference book for the practitioner.

It is scarcely necessary to say that the publishers have made it a very attractive volume. *

The Refraction and Accommodation of the Eye and their Anomalies. By E. Landolt, M. D., Paris. Translated under the author's supervision by C. M. Culver, A. M., M. D., formerly clinical assistant to the author; Member of the Albany Medical Institute, etc. With one hundred and forty-seven illustrations. Philadelphia: J. B. Lippincott & Co., 1886. Cleveland: P. W. Garfield. Cloth, 8vo., pp. 600.

The author thinks that a knowledge of optics is as essential for one who treats eye diseases, as a knowledge of physiology to the general practitioner. He asserts that at least two-thirds of the patients who consult an oculist suffer from optical disturbances, and that even the surgery of the eye is closely connected with physical and physiological optics, for manual dexterity alone no longer suffices in the treatment of diseases of the eye.

As a thorough knowledge of mathematics is not possessed by most physicians, the author devotes the first chapter of this admirable work to a study of the mathematical refraction of the eye, beginning with the luminous point emitting its undulations, which radiate in all directions, following the latter from one medium to the other through a plane, and then through spherical surfaces, which form systems more and more complex. This chapter may be omitted, if one has no liking for mathematics, without interfering with the study of what follows.

The principles of optometry are fully explained, and fully illustrated by clinical cases. The illustrations are numerous and fine. The book is designed for the specialist, not for the general practitioner.

Rheumatism: its Nature, its Pathology, and its Successful Treatment. By T. J. MacLagan, M. D., New York: William Wood & Company, 1886.

In March, 1876, Dr. MacLagan introduced salicin to the profession as a remedy in acute rheumatism. At that time he claimed that rheumatism, like intermittent fever, was of malarial origin, and in this volume that theory is fully expounded. What quinine is to malarial diseases, salicin, and the salicyl compounds, are to rheumatism. The author is

very ingenious in his presentation of the subject, and the acknowledged great value of salicin, and its compounds, in the treatment of rheumatism, adds great strength to his arguments.

The Physiological, Pathological and Therapeutical Effects of Compressed Air. By Andrew H. Smith, M. D., late Surgeon to the N. Y. Bridge Co. (Caisson Work), Physician to the Presbyterian Hospital, New York, etc.

Practical Guide in Antiseptic Midwifery in Hospitals and Private Practice. By Henry J. Garrigues, A. M., M. D., Professor of Obstetrics in the N. Y. Post-graduate Medical School and Hospital. Visiting Obstetric Surgeon to N. Y. Maternity Hospital, etc.

The Modern Treatment of Eczema. By Henry G. Piffard, M. D., Clinical Professor of Dermatology, University of the City of New York; Surgeon to St. Elizabeth's Hospital, etc.

These three little volumes are the latest installments of the "Physician's Leisure Library," published by Geo. S. Davis, of Detroit.

1. Dr. Smith's experience in the class of cases furnished in the construction of the New York Caisson has afforded him facilities seldom enjoyed, and his deductions are of consequent importance.

2. Antiseptic midwifery is the latest craze. It undoubtedly has its value in dirty hospitals, where its carrying out will result in cleanliness, but in respectable private practice it is not needed. This little work gives all the details.

3. Eczema we always have with us, and Dr. Piffard's brochure will be found interesting and valuable.

A Laboratory Guide in Urinalysis and Toxicology. By R. A. Witthaus, A. M., M. D., Prof. of Chemistry and Physics in the Med. Dept. University of New York, etc., etc. New York: Wm. Wood & Co., 1886.

This is gotten up in convenient form, one page of each leaf being left blank, for notes. In size and shape the book is also convenient, since it can be easily carried in the pocket, and is so bound as to lie open on the desk.

Its exclusive use of the metric system will cause it to be in little demand by practitioners, but this will probably be an inducement to the student whose instruction is in this system.

A Manual of Obstetrics. By A. F. A. King, A. M., M. D., Prof. of Obstetrics and Diseases of women and children, Med. Dept. Columbia Univ., Washington, D. C., etc. etc., with 102 illustrations. Third edition. Philadelphia: Lea Brothers & Co., 1886. 12 mo. Pp. 376.

This is the best of the small hand-books on this subject. As an aid to students in following lecturers, and to refresh the memory of the young practitioner, it answers a good purpose. This edition contains only slight changes from its predecessor.

OUR ADVERTISING DEPARTMENT.

Our readers will do well to ALWAYS LOOK OVER THE ADVERTISEMENTS. They are an integral part of the JOURNAL, and should be so regarded. Below we speak more particularly of some of them. *Send a postal card to each one for sample and circulars*, if you have not already done so, and, if you mention this JOURNAL, we will assure you that you will get an ample supply. Try it.

ATTENTION is called to the new advertisement of Wyeth & Bro., of Philadelphia, who have added quite a number of new preparations and combinations to their list of hypodermic tablets. These tablets are specially prepared for the one purpose, and are very soluble and unirritating.

MALTINE, with its various combinations, is certainly one of the very best of the tonics and alteratives for children. Few preparations have ever reached such a point of steady demand as this.

CASMOLINE, either alone or as a basis, constitutes a most important factor among all external applications. It is entirely unirritating, while as a protective it is unexcelled.

LACTOPEPTINE —Although this is not the season when this remedy is in greatest demand, its virtues are such, nevertheless, as to keep it in fair demand in all seasons.

MR. HARRISON COLE, the optician, enjoys the full confidence of the profession in Columbus, and physicians from a distance need have no hesitation in dealing with him by correspondence.

THE CINCINNATI SANITARIUM, as shown by its regular reports, continues to maintain its reputation for the successful home-like treatment of all forms of nervous disease.

COLDEN'S BEEF TONIC.—The *Phil. Med. Times* speaks very highly of this combination of calisaya and aromatics with albuminoids obtained from beef, especially in chronic diseases, accompanied by debility, weakness, loss of appetite, and indigestion, and in incipient phthisis.

HORSFORD'S ACID PHOSPHATE.—Dr. W. S. Leonard, of Hinsdale, N. H., says he has used Horsford's Acid Phosphate in his practice for the past eight or ten years, and has been much gratified with the results obtained from its use. In various forms of dyspepsia it reaches a class of cases that no other medicine seems to touch, and he has repeatedly seen

patients, where opiates were contra-indicated, obtain refreshing sleep and rest at night from a single dose at bedtime.

PINUS CANADENSIS—Dr. T. N. Clark, of Reagan, Tex., says he has used this preparation in gonorrhea most successfully, and that he is now treating cases of chronic cervical endometritis, with granular ulcerations, and thinks it particularly indicated there. It was its employment in such cases which elicited Sim's encomiums of its merits.

ACID MANNATE.—This is a very agreeable laxative; agreeable, that is, both in taste and effect. Dr. Bathrick, of Battle Creek, Mich., lauds it very highly for the constipation of pregnancy.

THE CORNELL AND PHENEGER CO., of Columbus, will be found to be a perfectly reliable firm, and physicians can order from them instruments, drugs, or general supplies, with the assurance of honorable and liberal treatment.

THE POCKET BATTERY, of the Kalamazoo Company, is a very excellent little instrument. We have used one for some time, and find it to give very satisfactory results.

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COMMUNICATIONS.

HEREDITARY AND CONGENITAL SYPHILIS.

Read Before the Muskingum Valley District Medical Society, Zanesville, O.,
Nov. 26, 1886.

BY S. L. MCCURDY, M. D., DENNISON, O.

The late Prof. Gross accepted as conclusive that if a man was a soldier, in the late civil war, he had syphilis; Prof. Sturgis, of New York, in a recent lecture at the Post-Graduate Medical School, said that there were but few male adults who passed through life without contracting syphilis, and the statement has been made without contradiction that the introduction of syphilis on the Sandwich Islands reduced the population fifty per cent. If these statements, made by such good modern authority, be true, how very few children born to-day are free from the dreadful taint. From this are we to infer that the comforter is on the increase, and that history will repeat itself, when we may say with Boccaccio in reference to the Neapolitan outbreak of 1494, that "the finest cities of Italy were visited with a most terrible plague which began to show itself in a sad and wonderful manner, which he describes as appearing in certain forms of tumors in the groins or under the arm-pits, some as large as small apples, others as an egg, and afterwards purple spots in most

parts of the body, in some cases large and but few in number, in others smaller and more numerous, both sorts the usual messengers of death."

In this paper my intention is to consider certain forms of hereditary and congenital syphilis in the light of the literature of to-day, with a resume of the manner in which the disease is transmitted from parent to offspring.

By congenital syphilis we understand that form of inherited syphilis that appears with birth, and hereditary syphilis is an inheritance which, not being present at birth, shows itself months or years afterwards.

I shall consider principally how the child receives its inheritance, touching upon certain points as they appear in the offspring. The classification generally accepted is that syphilis may reach a child, first, by descent from the father; second, by descent from the mother; third, by direct infection.

The second and third modes will be accepted without further comment. But as to the first, viz., descent from the father, it will be an effort of this paper to show that such a transmission is impossible; that it is impossible for the father to transmit syphilis to his children unless it first be given to the mother of the child; or, in other words, for a child to have syphilis in the hereditary or congenital form its mother must have it.

As syphilis is due to a specific virus, the disease could not result from any other form of germ or specific infection. If we accept the germ theory as being no longer a theory, but a fact, we must also admit of an individuality of germs. That is, if it were possible to magnify a typhoid fever germ so as to make it appear as distinct to the human eye as a corkscrew cast is under a seventh, the educated could recognize the individual features or characteristics. Then a yellow fever germ would be recognized as such, just as a Celestial is recognized as a Celestial by the very prominent distinctive individual characteristics that none others have.

To continue: all forms of vital organisms have their individuality, from an ameba up. A vital cell has its five histological elements and without them all it is not perfect. Is it not as strictly true of a spermatozoon? Impregnation is the union of a healthy ovum with a healthy spermatozoon. The only portion of the male, then, that enters into the act of procreation is the spermatozoon, which, if healthy, has power to impregnate a healthy ovum; but if it be diseased, it loses its histological elements, and hence might we not conclude that, owing to this diseased

condition caused by a syphilitic germ entering into the spermatozoon, it has lost its power to impregnate?

My reasoning may be at fault, but in support of the general proposition I desire first to quote from Sturgis,* who says "that it is impossible for a child to have hereditary or congenital syphilis unless its mother first has the disease." In the same line of thought I desire to quote Colles's law as follows: †"One fact well deserving our attention is that a child born of a mother who is without obvious venereal symptoms, and which, without being exposed to any infection subsequent to its birth, shows the disease when a few weeks old; this child will infect the most healthy nurse, whether she suckles it or merely handles and dresses it; and yet this child is never known to infect its own mother even though she suckles it while it has venereal ulcers of the lips and tongue." Here he says this child will infect the most healthy nurse and yet it is never known to infect the mother. Mr. Hutchinson says: "We have all of us seen chancres on the nipple of wet-nurses. They are indeed not infrequent. We have, however, none of us seen such on those of the mother of infected children.

There is but an exceptional authority at my command, but says that a mother of a syphilitic child can suckle it with impunity. This proves, then, that one attack gives complete immunity from subsequent attacks, and to be proof one must have had the disease. I want to ask why the mother does not take the disease when the nurse does? Is there some special law by which the mother is shielded when all others are subjects for the infection? If a child infects a healthy wet-nurse it would just as surely infect a healthy mother; but, as you see by this accepted law, the mother does not take the disease, therefore she must already have it. How or when does the mother have the disease, and in what form does it show itself, or when does it run its course? Again, is it possible for her to have the disease in such a latent form as to escape detection by the family physician or members of the family? After his lectures on the subject I asked Dr. Sturgis the foregoing question, and he said it was certainly possible for a mother to have it in such a mild form as to escape detection.

Van Buren and Keyes, page 520, say: "The male loses the power of transmission seemingly before the female." Further quotations might

* FREDERICK R. STURGES, M. D., in *N. Y. Med. Jour.*, July, 1871; *Ibid*, 1873; *Chicago Med. Jour.*, 1875.

† Diday's Work, Wood's Library, 1883.

be made and from all of them we learn that syphilis is not transmissible by the father in the tertiary stage, or after about the fourth year, but no distinction is made between the stages as to the limit of the mother's power to transmit the disease. Why, then, can we not say that just as long as the father is suffering with the acknowledged infective stages, the child may get it because he first gives it to its mother, and the mother passes it down to her offspring? But if the father has passed the stages of infection before he gets married, or before copulation is engaged in, the children are healthy because his power to communicate the disease to his wife has gone.

White, in Pepper's System, says: "It appears to be highly probable that no woman ever bears a syphilitic child and remains herself absolutely free from the disease," and "the mothers who have thus acquired an immunity have first done so by acquiring the disease."

Mothers, then, must have the disease in a mild form; just as varioloid is a modified form of variola, made mild by inoculation and not by infection. What modern Jenner will rise up above others and offer to a syphilitic race a means, by inoculation, of modifying the course of the disease so as to make it practically nothing as compared to its ordinary course; so that he who has the base desire can prowl about, boastful of his immunity from the fire of brothels. Then he will call upon his doctor for syphilitic inoculation, or vaccination, as a school boy does for vaccination during an epidemic of smallpox.

As to the peculiar notching of strumous children, known as Hutchinson's teeth," it may be observed that they are only found in children that have the strumous diathesis. The two upper incisors are termed the "test teeth." Since Mr. Hutchinson's first paper on the peculiar development of the teeth, Prof. Parrott, Fournier and others have made declarations concurring with him. The conclusion to be drawn is that syphilitic teeth are not always present in children suffering with the inherited form of the disease, but that when they are found it may be taken as sufficient evidence that such children will improve under specific medication.

The only disease that is likely to be mistaken for inherited syphilis is the affection known as scrofula. Lynch, in Pepper's System, says: "In this disease we see the same tendency to increased cell-production, the same tedious, slow and intractable inflammations and ulcerations which are characteristic of scrofula." The similarity has induced many persons to believe that scrofula is nothing else than syphilis in the second or third generation. Quite a number of cases that have presented

themselves with a true strumous history have yielded just as kindly to mercurial inunctions and the iodides as did those cases that were typical cases of syphilis with a typical syphilitic history.

Erichsen says there is no means of positively distinguishing syphilitic lupus from the so-called scrofulous variety. I have under observation a family of eight children, two of whom are dead with, as near as I can learn, "summer diarrhea." Within the last few years the younger children have had attacks of the same form of diarrhea. The ordinary remedies made no impression on the disease whatever. The very moment they were given specific treatment they began to improve. This family is what is known as a scrofulous family. No history of syphilis is obtainable.

Again, the similarity existing between scrofula and inherited syphilis will be seen in the report of about twenty cases of *purulent conjunctivitis*, occurring in private practice during the past four years. These cases were of what is commonly known as "scrofulous sore eyes." It was only possible to obtain a syphilitic history in a portion of the cases, less than one half, and a scrofulous history in the other cases. In the treatment of these cases no distinction was made, they all being placed on constitutional treatment, somewhat after the following for a child two years old:

R. Syr. ferri iodidi, ...
Syr. sarsap. co., ... aa. ʒiv. M. Sig.

Twenty drops every four hours.

This was given after taking milk or other food, never on an empty stomach, with hydrarg. cum creta, one grain, three times each day.

The mothers of these children, when suffering with the ordinary complaints, would improve under specific medication almost invariably.

Another point in the treatment is whether the treatment administered to the father, as is frequently done, is a useless procedure or not. If it be impossible for the father to transmit the disease to his offspring *per se*, then such treatment given with a hope of making an impression on the child, is entirely useless. Sturgis and Diday are advocates of this doctrine.

Without further comment the following cases are respectfully submitted:

CASE I. Male, who had passed through the different stages of the disease, was married seven years after receiving the initial lesion. About one year after marriage an apparently healthy girl was born. In about

one year after the birth of the child its mother was attacked with sciatica of a severe form, which would not yield to the ordinary remedies. Finally she was given iodide of potassium, one ounce in one ounce of water, five drops three times daily after eating, in water, the dose being increased two drops daily. In about one week the pain had almost entirely left. In a few more days it disappeared and has never returned. The medicine, however, was continued for some time. The child, born apparently healthy, had an attack of summer diarrhea that was just as stubborn to the ordinary remedies as the case of its mother. The child was given syrup of the iodide of iron, and the diarrhea was entirely well in a few days.

CASE II. Summer diarrhea, in a child of syphilitic parents, that would not yield to the ordinary drugs, but promptly improved under the treatment just given.

Other cases might be given, but the foregoing are true cases of syphilitic diarrhea that must have specific treatment to be cured. The doctor is frequently consulted by women suffering with headache, constipation, nervousness, sleeplessness, loss of appetite, disturbances of menstruation, premature grayness and decay, neuralgias, looking apparently well, that have been inoculated with the disease in such a way as to have it run the mild or modified course. Such cases can always be improved by anti-syphilitic treatment.

The conclusions to be drawn then from this paper are,

First—That a father cannot transmit syphilis to his offspring directly unless the mother of the child has the disease.

Second—That scrofula is an inherited form of syphilis.

Third—Treatment given to the father will have no influence on his offspring.

Fourth—That there is a mild or modified form of syphilis which always shows itself in mothers of syphilitic children.

THE DURATION OF INFECTIOUSNESS in the acute infectious fever is placed by Dr. Fredrick Pearse (*British Medical Journal*) as follows: Measles, from the second day, for exactly three weeks; small-pox, from the first day, under one month, probably three weeks; scarlet fever, at about the fourth day, for six or seven weeks; mumps, under three weeks; diphtheria, under three weeks.

NOTE ON THE TREATMENT OF THE UMBILICAL CORD.

BY JOHN I. KING, M. D., BURGH HILL, OHIO.

Sometimes we have trouble in securing thick umbilical cords properly. I tie all cords in the following manner: about an ordinary Hamilton's fenestrated artery forceps take three or four turns with a small rubber band, used now so commonly for light parcels, seize the cord with the forceps at the point you wish to apply the ligature, cut the cord about an inch external from this, turn the cut end between the blades of the forceps, roll the band off the forceps and the cord is most securely ligated, as the band will follow all shrinkage. It has advantages over the steel clamp, being neater, less cumbersome, and inexpensive. In dressing the child always turn the cord transversely upon the abdomen, so that the child may not make traction or pressure upon the attachment of the cord in its movements, a frequent cause of discomfiture to the little one when the cord is laid upward along the abdomen.

TYPHOID FROM A SINGLE DOSE.—

M. Dujardin-Beaumetz has forwarded to the Paris Academy of Sciences a communication on the Pierrefonds typhoid cases last summer. M. Fernet, who occupies a high post at the Ministry of Public Instruction, his wife and family, hired a house at Pierrefonds, a fashionable resort near Compiègne, contiguous to two others. After they had rented it for the season they were told to beware of the water in the well. On this account they drank exclusively mineral water until the last day, when the stock was out, and the servants were too busy preparing to return to Paris to go to fetch some bottles from the chemist. Madam Fernet said, "For once surely there can be no harm in drinking the well-water." They drank it. Six out of the nine persons have died, including one of the servants. The cook, two of the four children, and Madame Fernet had had typhoid fever before, and though attacked again by it after their return from Pierrefonds, have got through the illness. The well has been examined and is reported to contain the bacilli which are believed to be associated with typhoid fever. This is a common danger to which visitors to so-called health resorts, both on the continent and at home, are frequently subjected. The facility with which well-water is infected is hidden from the population by the impunity with which filthy well-water may often be drunk by resident families who have become acclimatised. especially when that water is for the moment infected only by non-poisonous fecal matter, and this

In cases of acute or subacute muscular rheumatism, or in subacute articular rheumatism with much pain and only moderate swelling of the joints, he often employs bromide of ammonium, or, if this fails, nitrate of potassium. He uses opium sparingly, and generally confines it to a moderate dose or two of Dover's powder, given at night.

He strongly insists, no matter what plan of treatment be adopted, on the addition of quinine, from twelve to sixteen grains daily, as soon as the more active symptoms have subsided, believing that thereby the patient's strength is sustained and relapses prevented.

From tincture of chloride of iron he has seen no good, except in pyemic rheumatism or in kindred forms of rheumatism.

Locally, he uses little, enveloping the swollen joints, if very painful, in a thin layer of cotton-wool; where the joints are very much swollen he envelopes them in cloths wrung out in a strong solution of nitrate of potassium, with morphia added.

The diet is always bland and unstimulating, chiefly milk, farinaceous substances, and very moderate amounts of broths, eggs and fish. Alcohol is not given except in the so-called "typhoid cases," in which also high temperature is generally found.

Dr. Bartholow find that the cases which comes under his observation may be divided into three types: The robust nervo-muscular subject, often having a distinctly hereditary tendency to the occurrence of rheumatic inflammation; the obese, beer-drinking subject; and the pale, anemic, feeble subject, most frequently female, living under unfavorable hygienic conditions, and leading a closely sedentary life.

His choice of remedies for these three classes of rheumatic subjects, when the seizure has actually occurred, is confined to the salicyl compounds for the nervo-muscular type, to alkalies and tincture of iron in the obese type, and to tincture of iron in the anemic. The recent additions to our knowledge of the good effects of antipyrin in acute rheumatism incline him to use it in place of salicin and salicylic acid, and for the hyperpyrexia in any of the cases. Although he cannot agree with those enthusiasts who regard antipyrin as a specific in rheumatism, he cannot overlook the good effects obtained from it in appropriate cases—especially in the neuro-muscular group. As the disease manifests a tendency to relapse the earlier and the more abruptly defervescence and cessation of pain take place, he keeps up the use of the remedies for several days after all morbid manifestations have ceased. With these remedies he

combines, *pro re nata*, quinine, morphine, and more particularly, blisters in the neighborhood of the affected joints.

In the obese, beer-drinking type of rheumatics, the use of alkalies, or the combined alkaline and quinine treatment as advocated by Fuller, appears to him to be most efficacious during the existence of the acuter manifestations. When these have distinctly subsided, the tincture of iron freely administered becomes the most important remedy, and will do more than any other to prevent recurrences, which are particularly apt to take place in this type. Furthermore, the acute rheumatism of these obese subjects manifests a certain sluggishness of disposition, so to speak, and slowly glides into the subacute and chronic forms. Until he learned the value of tincture of iron in these cases, he had to observe this tendency of the malady only too often.

For the third group of rheumatic cases, he uses the tincture of iron with excellent results. The anemia, the depression of the bodily forces, and the exquisite sensibility characteristic of this type, are conditions generally improved by iron; but as no other preparation manifests the same power in acute rheumatism, there must be a special action due to the hydrochloric acid in the combination. This view is more probable, since the mineral acids have themselves been used successfully in the treatment of this disease.

The blister treatment, which has alone accomplished excellent results, may well be combined with any other special plan.

Whatever mode of treatment has been pursued, he finds it necessary to keep it up, somewhat modified as to quantity, for several days after the apparent cessation of the systemic and local disturbance.

Dr. Morris Longstreth, Pennsylvania Hospital, in cases of decided articular manifestations and high temperature, orders salicylic acid to be given in ten grain doses every hour until six doses are given—*i. e.*, a drachm every twenty-four hours. The salicylic acid is given with the object of reducing the temperature, and the quantity and frequency of the dose are proportioned carefully to the end to be attained. In the large majority of cases it is successful. The temperature, and with it the frequency of the heart's action, diminishes. Cardiac complications, endo- and peri-carditis, do not seem to contraindicate its employment or its continued use. Occasional cases present themselves in which great depression of the heart follows the employment of the drug in large doses, even without evident inflammatory cardiac complications. In such cases, other

medication must be employed; and occasionally restoratives have been required to overcome the effects. Usually its use is continued for one or more days after the subsidence of the temperature, in much reduced doses and at longer intervals.

In cases in which salicylic acid fails of its usual effect, or in cases with great anemia or previous debility, salicin has been found very useful. It has been given in fifteen grain doses, four times a day. Its administration in smaller doses is often continued during convalescence, either alone or in connection with iron or other tonics.

The alkaline treatment Dr. Longstreth resorts to less frequently. When employed, bicarbonate and citrate of potash, in equal portions, are given in divided doses to the amount of one ounce daily.

Quinine and tr. ferri chloridi seem to be demanded during convalescence in nearly all the cases. The disordered digestive functions, evidenced by coated tongue and sluggish bowels, seem to be most favorably and promptly aided by the administration of small doses of calomel, gr. $\frac{1}{8}$, with bicarbonate of soda, gr. ij , given at frequent intervals during one or two days.

Locally, to the affected joints, three modes of treatment have been found of service. Joints hot and tense are covered with cloths wet with lead-water and laudanum, equal parts, and enveloped with waxed paper or gutta-percha sheeting. In some cases, the local application of saturated solution of bicarbonate of soda is useful; sometimes the impermeable sheeting is omitted from the dressing—coolness from evaporation being more comforting than the heat. In other cases, the joints are enveloped in cotton, with or without the covering.

Cold-water sponging or packing is employed in cases of high temperature with delirium. Antipyrin has been employed in some of these cases, but without good results. Morphia or opium is always used as required.

Dr. James Tyson, Philadelphia hospital, uses both salicylic acid and salicylate of sodium, but recently has confined himself rather more to the former. He gives it preferably in the form of a compressed five grain pill, of which two are ordered every two hours until the symptoms yield. This is generally within twelve hours, and almost always within twenty-four. After the pain has decidedly subsided he diminishes the dose one half, or increases the interval to four hours. If the administration is cautiously continued for a week or ten days, he finds that it is

comparatively seldom that relapses occur. Sequelæ and complications are less frequent by this than by older methods of treatment. It is comparatively seldom that anodynes are required as adjuncts to relieve the pain, but when they are, the hypodermatic use of morphia is promptly efficient.

In giving the salicylate of sodium, he prescribes ten to fifteen grains every two hours, or half as much every hour until relief is obtained. Its sickening taste in solution is a great drawback to its use, but it, too, may be given in five grain compressed pills, although the larger bulk makes this method of administration inconvenient.

When salicylic acid or its salts fail, he finds that flying blisters to the painful joints are the next most efficient measure, and their effect upon the pain is usually very prompt.

Dyscrasic cases are, of course, treated with iron, quinine and an abundance of nourishing food, and flannel garments worn next to the skin.

In muscular rheumatism salicylic acid is seldom efficient, although Dr. Tyson often uses it with results which lead him to believe that it is not totally without effect. By far the most satisfactory measure is dry heat, applied most conveniently by the hot water bag.

In the treatment of chronic rheumatism Dr. Tyson has much more confidence in the use of local measures and manipulation. Salicylic acid is also sometimes useful, but the effect is more frequently temporary.

Dyscrasic conditions are treated with cod-liver oil and iron, which alone are sometimes curative. Counterirritation by blisters and strong liniments are sometimes useful adjuncts, but are in no degree equal to manipulation.

Dr. J. C. Wilson has, during the past three years, used in acute rheumatism a mixed treatment, consisting of sodium salicylate in combination with sodium bicarbonate or sodium acetate. The formula commonly employed is as follows:

R.—Sodii salicylatis	.	.	.	gr. xv.
Sodii bicarbonatis	.	.	.	gr. xxx.
Aqua menth. pip.	.	.	.	℥ss. —M.

To be taken every third or fourth hour.

This dose is increased or diminished in accordance with the intensity of the pyrexia, the acuteness of the joint pains, and the condition of the heart, in individual cases. After the reaction of the urine becomes distinctly alkaline under this treatment, the sodium bicarbonate is stopped,

and the salicylate continued alone at gradually increasing intervals until the pains and fever have wholly ceased. The administration of iron then follows, usually in the form of Basham's mixture, the *mistura ferri et ammonii acetatis*, U. S. P.

Dr. Wilson regards this method as quite equal to the treatment of salicylic acid, the sodium salicylate alone or by salicin, as regards the rapidity with which the pain is relieved and the fever controlled, and as much superior to them in the diminished danger of producing the toxic effects of large doses of the salicylates, especially cardiac depression, epistaxis, tinnitus, headache, and maniacal excitement—phenomena which are very seldom observed, if we except slight ringing in the ears, under this plan of treatment.

The diet consists chiefly of milk; light broths are, however, occasionally permitted, to which, with beginning convalescence, are added bread, rice, custards, etc. Alcohol in any form or dose is scarcely ever given except in emergencies, and forms no part of the treatment even during convalescence.

Serious heart complications developed under observation in the wards are comparatively infrequent, and relapses not very common.

In view of the frequency of recognizable cardiac lesions, especially in young subjects, and of the probability that some degree of implication of the valvular endocardium, not sufficient to manifest itself by satisfactory auscultatory signs, may be present in many cases, in which murmurs are not present, the patients, when practicable, are kept in bed for ten days or two weeks after the complete subsidence of the acute symptoms. The valves of the heart are thus saved wear and tear, the danger of relapse is greatly lessened, and the rebuilding of the blood hastened.

If, despite the steady use of iron in full doses, the anemia persists, arsenic is given in small but gradually increasing doses, usually with good effect.—*Phil. Med. News*.

PARVULES.—This is a coined word, meaning small doses in globular form for frequent repetition, usually divided into periods of one hour each. It is claimed in its behalf that it is the only perfect dosimetric system of administering medicines. That is to say the quantity and frequency also must determine the therapeutic effect. It enables the physician to regulate with certainty the action of the drug, the rule being one parvule every hour or two every two hours. Any age can be suited. This does not compromise allopathy because reference to the list of

this class of remedies prepared by Wm. R. Warner & Co., of Philadelphia, will show that in nearly all cases 24 Parvules a day or the average of one per hour would be a full dosage. For instance, 1.50 gr. Morphia in each would be half grain a day, 1.20 gr. Podophyllin would be one grain and a fifth a day. In case of calomel it is a recognized fact that small doses produce wonderful effects. One or two Calomel Parvules taken every hour for six doses have marvelous effect. The Parvules of Aloin in certain cases, periodically taken, produce great effect and comfort. A logical explanation of the exact action of minimum doses is an impossibility in the present state of physiological investigation. Bartholow says that the therapeutical action is the physiological antagonist of the diseased action. The only certain principle of action, however, is found in actual experience. This may be observed fully noticed in the various medical journals throughout the world. Drs. Peters of Paris, Ringer, Bartholow, Dessau, and others, equally well known in the literary arena, have cited numerous cases of almost every variety of disease wherein they brought about a desired result by the adoption of minimum doses when all other plans of treatment had failed. The Parvules are elegant in form and certain in action. Their mode of preparation, together with their action upon secreting surfaces, prevent cumulative effects. Dr. Campbell, of Liverpool, writes enthusiastically of the good results which he obtained from the frequent administration of small doses of belladonna in the sickness of pregnancy. In the treatment of diseases of infancy they are of unquestioned value. The dose and effect can be regulated with the utmost precision, while their diminutive size, with an absence of taste, render them of peculiar service. It requires an immense amount of patience, persuasion, and sometimes force to give even the most palatable liquid preparation to children. The Parvule is so readily dissolved by the secretions of the *primæ viæ*, that an immediate effect is produced without discomfort to the infant.

SUPRA-CLAVICULAR ADENOPATHY IN CANCER OF THE STOMACH.—

The presence of swollen cervical glands is sometimes an indication of cancer of the esophagus, lungs, pleura, or other intra-thoracic organs, but it is not generally recognized that a supra-clavicular adenopathy may be present also in cancer of the stomach. Several German and French writers have recorded instances of this kind, however, and more recently M. Troisier related three cases at a meeting of the Hospitals Medical Society of Paris. In two of the cases an autopsy could not be made, but the

clinical history left no room to doubt the correctness of the diagnosis. In the third case, cancer of the large cul-de-sac and pyloric end of the stomach was found, but the esophagus was not involved in the morbid process. The ganglia in the immediate neighborhood of the stomach were not degenerated, but those in the supra-clavicular region were manifestly cancerous. In each of these cases during life several enlarged and indurated, but not painful, glands were noticed in the supra-clavicular region of the left side, behind and to the outer side of the sternocleido-mastoid muscle. Some of the glands were isolated, others confluent; they were not adherent to the skin, but could be rolled like marbles under the finger.—*Med. Record.*

MANAGEMENT OF SIMPLE CONSTIPATION.—Sir Andrew Clark gives the following instructions for the management of simple constipation.

1. On first waking in the morning, and also on going to bed at night, sip slowly from a quarter to half a pint of water, cold or hot.

2. On rising, take a cold or tepid sponge bath, followed by a brisk general towelling.

3. Clothe warmly and loosely; see that there is no constriction about the waist.

4. Take three simple but liberal meals daily; and, if desired, and it does not disagree, take also a slice of bread and butter and a cup of tea in the afternoon. When the tea is used it should not be hot or strong, or infused over five minutes. Avoid pickles, spices, curries, salted or otherwise preserved provisions, pies, pastry, cheese, jams, dried fruits, nuts, all coarse, hard, and indigestible foods taken with a view of moving the bowels, strong tea, and much hot liquid of any kind, with meals.

5. Walk at least half an hour twice daily.

6. Avoid sitting and working long in such a position as will compress or constrict the bowels.

7. Solicit the action of the bowels every day after breakfast, and be patient in soliciting. If you fail in procuring relief one day, wait until the following day, when you will renew the solicitation at the appointed time. And if you fail the second day, you may, continuing the daily solicitation, wait until the fourth day, when assistance should be taken. The simplest and best will be a small enema of equal parts of olive oil and water. The action of this injection will be greatly helped by taking it with the hips raised, and by previously anointing the anus and the lower part of the rectum with vaseline or with oil.

8. If by the use of all these means you fail in establishing the habit of daily or of alternate daily action of the bowels, it may be necessary to take artificial help. And your object in doing this is not to produce a very copious dejection, or to provoke several smaller actions; your object is to coax or persuade the bowels to act after the manner of nature by the production of a moderate more or less solid formed discharge. Before having recourse to drugs, you may try, on waking in the morning, massage of the abdomen, practised from right to left along the course of the colon; and you may take at the two greater meals of the day a dessertspoonful or more of the best Lucca oil. It is rather a pleasant addition to potatoes or to green vegetables.

9. If the use of drugs is unavoidable, try the aloin pill. Take one half an hour before the last meal of the day, or just so much of one as will suffice to move the bowels in a natural way the next day after breakfast. If it should produce a very copious motion, or several small motions, the pill is not acting aright; only a fourth, or even less, should be taken for a dose. When the right dose has been found it may be taken daily, or on alternate days, until the habit of daily defecation is established. Then the dose of the pill should be slowly diminished, and eventually artificial help should be withdrawn. The aloin pill is thus composed: R.—Aloinæ, $\frac{1}{2}$ gr.; extr. nucis vom., $\frac{1}{2}$ gr.; ferri sulph., $\frac{1}{2}$ gr.; pulv. myrrhæ, $\frac{1}{2}$ gr.; saponis, $\frac{1}{2}$ gr.; fiat pil. 1. If the feces are dry and hard, and *if there is no special weakness of the heart*, half a grain of ipecac may be added to each pill. Should the action of the pill be preceded by griping and the character of the action be unequal, half a grain of fresh extract of belladonna will probably remove these disadvantages. If the aloin pill gripes, provokes the discharge of much mucus, or otherwise disagrees, substitute the fluid extract of cascara sagrada, and take from five to twenty drops in an ounce of water either on retiring to bed or before dinner. And when neither aloin nor cascara agrees, you may succeed by taking before the mid-day meal two or three grains each of dried carbonate of soda and powdered rhubarb.

The exact agent employed for the relief of constipation is of much less importance than its mode of operation. If, whatever the agent may be, it succeeds in producing after the manner of nature one moderate formed stool, it may be, if necessary, continued indefinitely without fear of injurious effects. But, treated upon physiological considerations, I have the belief that in the great majority of cases simple constipation may be successfully overcome without recourse to aperients.—*Lancet*.

RUBELLA.—While the broad lines separating measles and scarlatina are universally recognized, there has been anything but harmony among writers concerning certain anomalous forms of eruptive fever prevailing from time to time which present mingled characters of the two affections, or which appear to present the features of an independent affection. Ever since the middle of the last century, they have attracted much attention, and while, for the most part, they have been considered as aberrant forms of measles or scarlatina, there can be noticed a constantly recurring disposition to gather together, under a special designation, certain cases occurring sporadically or epidemically, which seemed to offer peculiarities distinguishing them from these two diseases. Gradually all affections having a red macular eruption, and not recognizable as measles or scarlatina, came to be described as rotheln, and great confusion resulted, but within the last twenty years the question has assumed a phase that gives hopes of its satisfactory solution.

The latest writer on the subject is Dr. I. E. Atkinson, who, in the January number of *The American Journal of the Medical Sciences*, studies the disease in a systematic manner, both historically and clinically. His conclusions are that

1. Rotheln is a specific, contagious, eruptive disorder.
2. While it possesses characteristics which, taken together, justify a reasonable degree of certainty in its diagnosis, it has 'no symptom that may not be and is not often assumed by measles.
3. A sporadic case, occurring in one who has never had measles and who affords no history of exposure to rotheln, may be diagnosticated with a fair degree of confidence, but not with absolute certainty.
4. The unqualified diagnosis of rotheln should only be made during an epidemic in which all persons exposed, irrespective of former attacks of measles, are liable to be affected and in whom the symptoms follow a pretty uniform type. In the absence of a pronounced epidemic influence, a series of cases occurring in a household, a school, or an asylum, showing typical symptoms, may be diagnosticated as rotheln with a fair degree of confidence.
5. In sporadic cases, where neither measles nor rotheln has been experienced, a diagnosis of probable measles or rotheln must be made, as conditioned by the resemblance of the symptoms and course to the type of one or the other affection.

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 **BEWARE OF IMITATIONS.**

OBSTETRICS.

THE ALTERNATIVES TO CRANIOTOMY.—Dr. Robert Barnes (*Brit. Med. Jour.*) read a paper before the British Medical Association on this subject in which he draws the following conclusions :

1. The legitimate aspirations and tendency of science is to eliminate craniotomy on the living and viable child from obstetric practice.

2. The advance of hygienic rule, the improvements in the forceps, in turning, in the induction of labor, and in obstetrics generally, have materially curtailed the field within which craniotomy can be justifiable.

3. In the most extreme degrees of pelvic distortion, where delivery *per vias naturales* can only be effected with doubtful success to the mother, Porro's operation is the legitimate alternative for craniotomy, it being understood that the opportunity of inducing abortion has gone by.

4. In less advanced degrees of pelvic contraction, but still incompatible with the delivery of a living child *per vias naturales*, the opportunity of inducing abortion having gone by, but in which craniotomy would effect delivery with strong presumption of safety to the mother, the Cæsarian section may be a proper alternative for craniotomy. This is the most debateable point.

5. In the minor degrees of contraction, say from three inches to three and a half or three and three-quarters inches, the opportunity of inducing labor having gone by, the far greater safety to the mother obtained by craniotomy, and the prospect of living children in future pregnancies by inducing labor, make craniotomy the proper course to adopt.

6. In other emergencies than deformity, as in obstructed labor from ovarian tumors, the alternative to craniotomy is to remove the tumor.

7. In cases of immovable tumors, Porro's operation is the proper alternative.

8. In rupture of the uterus, the child being delivered or not, Porro's operation is the proper alternative. There the interest of mother and child coincide.

9. In cases of disease or tumors of the uterus obstructing delivery, Porro's operation is the proper alternative.

10. In atresia of the cervix or vagina, Cæsarian section or craniotomy may be necessary ; but incisions and gradual dilatation will more frequently be the proper alternatives.

study have made him master. This has been, practically, the teaching of Prof. Schroeder, of Berlin, in regard to the application of the forceps to the after-coming head. In the majority of cases this is no easy operation—an item which obstetrical writers are apt to overlook—and at times impossible even in the hands of the most experienced. In those cases in which it can be accomplished, the *modus operandi* is quite a different thing from the application of the forceps in head-first cases, and the average medical man by much delay assures the death of the child, and by awkward manipulations, the injury of the mother's soft parts. Recognizing these facts, Schroeder has always taught that when a head can not be extracted by the usual methods, perforation should be done, as the safest method of effecting delivery.

Prof. Crede, of Leipsic, has, however, recently come forward with a report of sixteen cases, in which, after manual attempts at extraction had failed, delivery was accomplished by forceps, with the result of saving twelve (12) of the children. "If," he says, "these cases had been handled according to the method of Schroeder, the entire number of twelve which we saved, must have perished."

This would seem to indicate that Schroeder is altogether too hasty in his advice to perforate. But is it so? The Berlin professor, writing for the benefit of students and general practitioners, does not lose sight of the fact, and, from his large experience, advises what he believes to be the safest method. Crede quotes in his article—which is more particularly intended for specialists—the results of the use of forceps in the hands of *experts*. If we look over the statistics of head last cases, we find that there is but a very small percentage of all the number which cannot be extracted by the method known as the Prague, or the Smellie-Veit method.

Granting that there is a small percentage of cases which cannot be thus dealt with successfully, we must subtract from this number those cases which, because of abnormal conditions, either fetal or maternal, cannot be born without perforation, and the actual number of cases left where the forceps might in expert hands prove of use will be so surprisingly small, that the general practitioner could hardly hope to meet with more than half a dozen such during a long experience.

It is not to be denied that the forceps is often applied to the after coming head and successful delivery effected, where, in most cases, if not in all, proper manual efforts would have succeeded.

So limited, however, are the opportunities for the study of operative obstetrics in this country that many practitioners, and particularly the

young men, find great difficulty in delivering the head by the methods mentioned. Most have, however, acquired more or less facility in the use of forceps, and there can be no hesitancy in saying that in such a state of affairs it is much wiser to attempt an instrumental delivery at once, rather than to run the risk of losing the child by the manual methods.

But while this may do for the man of little experience, the older practitioner will find that the manual extraction is easier, safer, and quicker than the application of the forceps, and in those cases where the head cannot be extracted by these means, the forceps offers little in the way of hopeful results—*Amer. Lancet. Arch. of Gynecol.*

TREATMENT OF INFANTILE SYPHILIS. (DIDAY.)—In severe cases, one should begin by prescribing two-thirds of a centigram of corrosive sublimate, or one centigram of the soluble mercury of Hahnemann, in three doses, in twenty-four hours. This should be increased by one-third of a centigram every three days, until a sensible effect is produced upon the mouth, or upon the syphilitic symptoms. Then diminish the daily quantity, as in the case of adults, so as to maintain a slight action upon the gums. Once each day friction should be made with one or two grams of simple mercurial ointment (mercurial cerate) to begin with. A larger quantity, if necessary, may afterwards be used for each friction. If the skin is too sensitive, use frictions only every other day. Every second, third, or fourth day, a bath additioned with two grams of the sublimate is to be employed. Later increase the quantity of sublimate gram by gram, until the bath contains four to six grams, according to the age of the patient. The duration of the bath should be about one-half hour.

Internally, iodide of potassium may be given in a commencing dose of five centigrams, and rapidly increased. In many cases it will be found advantageous to associate the iodide with mercury in the form of a mixed treatment. For example, the *liquer de van Swieten* may be prescribed in teaspoonful doses in milk or sugared water.

In applying these precepts, due regard should be had to the age of the infants, their strength, their development, and the intensity of the disease to be combated.—*Gaz. Med. de Nantes.—Jour. Cut. & Ven. Dis.*

THE EFFECT OF RETAINED MEMBRANES ON THE PUERPERAL STATE.—Dr. Fisher, of Professor Slavianski's clinic, writing in a recent number of the *Vratch*, gives the result of a number of observations made for the purpose of testing the commonly received view that portions of mem-

brane retained in the uterus after the expulsion of the placenta are liable to produce serious consequences—a hemorrhage and especially the so-called auto-infection or septicemia,—and that therefore it is of the utmost importance that they should be removed by the hand or by intra-uterine injections. This view is supported by the authority of Winkel, Dohrn, Ahlfeld, and others; while Olshausen, Crede, Weiss, and Landau consider that there is little harm in the retention of even considerable portions of the chorion. Dr. Fischer's observations extended over 682 labors, in each of which he carefully examined the after-birth. In forty-two of these cases (*i. e.*, 6.2 per cent.) a portion of the chorion was retained. Crede's method of manipulating the fundus uteri gave the best results regarding the percentage of retention. In primiparae retention was nearly twice as frequent as in multiparae, the percentage being 9.1 and 4.9 respectively. Some effect appeared to be exerted by the time at which the rupture of the amnion took place, which, when either too early or too late, seemed to predispose to retention. Premature deliveries also were rather more frequently followed by retention than those at term. As a rule, the retained chorion came away in the course of from four to six days, generally in several small portions, sometimes, however, in fragments of considerable size, and in one case, where three-quarters of the chorion had been retained, it was passed entire on the fifth day without having caused either hemorrhage or sepsis. Amongst the forty-two cases, hemorrhage occurred only four times, and was always easily arrested either by hot irrigation or by ergot and manipulation of the uterus. When, however, we learn that out of the forty-two cases manual extraction of the fetus was required seven times, and that a considerable loss of blood occurred during the third stage eleven times, four cases of slight post-partum hemorrhage do not appear at all excessive. With regard to pyrexia, in twenty cases, or 47.6 per cent., there was none; in twelve, or 28.6 per cent., the thermometer, which was always used thrice a day, once registered a rise above normal; and in ten, or 24.8 per cent., there was more or less pyrexia. In order to compare these with cases in general, Dr. Fisher gives the result of similar observations made on all the cases he has attended for the last two years. These show that there was no pyrexia in 58 per cent., that the temperature was only once above normal in 17.6 per cent., and that there was pyrexia in 24.4 per cent.; so that the ratio of appreciable pyrexia was about the same in the cases in which retention occurred as in ordinary cases. A slight amount of endometritis occurred in three out of the forty-two cases. Dr. Fisher

concludes from his observations that there is no ground for supposing that retention of fragments of membrane gives rise to "auto-infection," and considers that the commonly received view is fraught with danger, inasmuch as it tempts the accoucheur, when sepsis occurs, to throw the blame, not on himself, as he ought to do, but on some fancied auto-infective process, and thus probably prevents his being as particular as he should be in employing antiseptic methods in the management of the labors he has to tend.—*Quar. Compend.*

INTUSSUSCEPTION IN CHILDREN.—Dr. W. E. Foster (*Am. Jour. of Obstet.*) gives us a very interesting paper on intussusception in children, the diagnosis and treatment of the same. He mentions that in making a diagnosis we are to look to the character of the evacuations which resemble dysenteric discharges, but contain more blood and less mucus than these discharges. We may expect to find a tumor which can be felt by palpation over the abdomen, and the pain will be great and resemble somewhat the pain of colic, also in those cases that have come under his observation the sphincter ani has been very much relaxed. Then the constitutional reaction, the throes and straining without passing feces but with passage of blood, are the characteristic symptoms. He recommends a very practical instrument for giving injections of air and water in a carbonic siphon attached to a syringe tube, and by pressing the cock the injection and amount can be regulated at will. He can not agree with some authors in believing that we should trust to nature to cure these cases, as the per cent. of natural cures is quite small, and even if the portion that has been occluded sloughs, the patient will probably die of exhaustion if left to nature.—*Quar. Comp. Med. Sci.*

HOUSEMAID'S KNEE.—Geo. Saunders, M. D. (*Brit. Med. Jour.*) says: "In the first two stages of the disease, surgical writers advise, after tapping by means of a small trocar or aspirator, the employment of pressure by means of strapping. It has been my practice not to use strapping, but a piece of lead about the size and thickness of a crown piece, wrapped in lint, and placed over the patella, which should be continued for about a month. Previous to tapping, the part should be painted with iodine, and also occasionally afterwards. I have not considered it necessary to confine the patient to bed longer than two days. I have treated bursæ on the back of the wrists on the same plan with satisfactory results.—*N. Y. Med. Abstract.*

SURGERY.

DIAGNOSIS AND TREATMENT OF SHOT-WOUNDS OF THE INTESTINES.—This subject was fully discussed at the last meeting of the New York State Medical Association.

As to *diagnosis*, Dr Joseph D. Bryant, of New York, said that there were two classes of symptoms: one referable to the abdomen itself, and one to the constitutional effects of the injury. In studying the local evidences of trouble, the surgeon would investigate the wound of the abdominal wall, the direction of the missile, the character of the discharges, and the presence or absence of emphysema of the borders of the wound, or in the neighboring connective tissue. If the direction of the ball indicated that the peritoneal cavity was penetrated, the presumption was that the intestines were wounded. Still, there were cases on record in which the cavity had been penetrated, and yet the intestines remained uninjured. If the bleeding points of the abdominal wall would not account for the amount of hemorrhage present in any case, it was altogether likely that the intestines were perforated. The same was true if there was bloody urine. Of course, the escape of the intestinal contents was proof positive of perforation, but this was rarely met with soon after the injury. Emphysema was not very frequently seen, but when present, it was almost invariably due to the escape of gas from the intestines. Early emphysema of the abdominal wall had been regarded as a positive sign of intestinal perforation, but while this was true, as a general rule, he had personally met with two instances in which the emphysema was caused by the suction of the abdominal muscles. If decomposition were present, emphysema might also occur without rupture of the intestines, but this was apt to be met with only quite late. Having referred to pain, tympanites, bloody stools, and retention as significant signs, he went on to speak of hepatic resonance. While this was almost pathognomonic, it was to be borne in mind that it might possibly be due to other causes. Thus, it might result from the transverse colon getting between the liver and the abdominal wall, or from the tilting of the liver out of its normal position. There might be shock and nausea and vomiting, hiccough usually following the latter. If there was severe shock from the first, it usually indicated intestinal perforation and hemorrhage. Extreme thirst, restlessness, anxiety and subnormal rectal temperature were all corroborative signs of perforation. There were, indeed, but very few positive early indications of the condition, but loss of hepatic dull-

ness, unless previously modified by change of position, or abnormal processes in the liver, was undoubtedly one of the most valuable.

Dr. W. T. Bull, of New York, spoke on the matter of *treatment*. He said that laparotomy was in general indicated, in the first place, for diagnosis. Many cases presented but few of the characteristic symptoms of perforation. Again, a bullet which had entered the peritoneal cavity was much more apt to have injured the gut than not. As to the time when laparotomy should be performed, he thought it should be done as soon as the immediate shock of the injury and of the removal of the patient were past. Delay only invited the onset of septicemia, and he did not think it advisable to wait for the appearance of symptoms. Exploratory laparotomy was not without good effect even in non-penetrating wounds. Since the year 1877 he had seen eight cases of penetrating shot-wounds of the abdomen at the Chambers Street Hospital. Five of these were treated on the expectant plan, and all proved fatal. In the other three cases laparotomy was resorted to, with the result of two recoveries and one death. In the first of the successful ones which had been reported in full in 1884, seven wounds in the intestines were sutured. The second occurred in August, 1886, and had recently been reported by Dr. Bull at a meeting of the New York Surgical Society. The patient was twenty-five years of age, and the operation was performed two hours after the receipt of the injury. Three wounds of the intestines were sutured, and two wounds of the mesocolon were not sutured, but rubbed thoroughly with iodoform. One of the appendices epiploicæ, of good size, which was found torn and bleeding at its extremity, was tied at its base with catgut and cut off. The external wound did not heal entirely for eight weeks, as there was sloughing of the peritoneum along the line of sutures, and protrusion of a portion of intestine which firmly adhered to the parieties. The edges of the wound were held together with two "relaxation sutures" of silver wire, and compression was made on the intestine with a small pad of iodoform gauze and wool. By means of these the gut was pushed back from day to day, while the edges were being drawn together and the lower part of the wound was filling with granulations. The man was now perfectly well and pursuing his usual avocations. The third and unsuccessful case was operated on November 6, 1886, and has not as yet been reported. The wound was made with a forty-four calibre ball. The incision was made in the median line, and four perforations of the intestines were sutured. The operation lasted one and three-quarter hours, and death, which was probably due to the shock from the laparot-

omy, occurred eight hours afterwards. Dr. Bull explained that none of these three cases presented any positive proof of perforation of the intestines before the abdomen was opened. Yet the lesions found in the last one, as well as in the others, indicated operative interference. Having briefly referred to the five fatal cases treated on the expectant plan, he went on to speak of the contra-indications for laparotomy. It was to be borne in mind, he said, that in many instances the solid organs, such as the liver, spleen and kidneys—though the latter did not present so serious a complication as the others—were wounded as well as the intestines; and he doubted the ability of the surgeon to cope successfully with such cases. Uncomplicated wounds of the intestines were not, in his experience, accompanied by profound shock; and profound shock was, therefore, a decided contra-indication. The exposure and handling of the viscera were not devoid of danger. Peritonitis was not, in his opinion, necessarily a contra-indication.

As to what should be the first measure of treatment, he advised that the bullet wound should first of all be explored; except in cases where it was situated posteriorly, with no wound in front. In general, the two rules which he would offer for guidance were: (1) Assure yourself by exploration that the abdominal cavity has been entered. (2) Proceed to repair the injury.

Dr. Theodore R. Varick, of Jersey City, thought that when there were present shock with gradual increasing exhaustion, sinking temperature, dullness on percussion of the dependent parts of the abdomen, and tympanites of the anterior portions, immediate laparotomy was demanded.

If the operation is considered a desperate one, he said, we should bear in mind that we have a desperate case to treat. The day of expectancy is past, and the time for bold and decisive action has arrived. Would not a surgeon be worse than a criminal to allow a patient whose life-blood is oozing away, whose peritoneal cavity is subjected to the contact of feculent matter, or, perchance, foreign substances from without, lighting up peritonitis and sepsis, leading to inevitable death, to die, when, in the light of surgical science of the present day, means are offered to stem the outflow of life, to remove by thorough cleansing of the peritoneal cavity all foreign substances, and by the various methods of continuous suture, close the door to further extravasation, and allow a conservative plastic exudation to complete what art commenced? Who would not at once remove a foreign body from an extremity the effect of

which would be simply the production of a limited amount of inflammation and suppuration? And how much more is it the duty of the surgeon to remove from the abdominal cavity more deadly material, whose presence, moment by moment, tends more and more to shorten life. If time enough has already elapsed to note a gradual descent of temperature, it indicates a continuous hemorrhage. If the temperature has ceased to fall and has begun to rise above the normal, inflammatory consequences are already initiated, but, possibly, it may not yet be too late to operate. At all events, give your patient the benefit of a chance, no matter how small, as against an almost absolute certainty of death.

Dr. Charles B. Nancrede, of Philadelphia, said that laparotomy should always be performed except when certain contra-indications were present. Among the indications referred to were the vomiting of blood or passage of blood per anum, the rapid accumulations of fluids in the abdomen, etc. As to the time for the operation, he thought it should be done just as soon as the patient's condition would warrant the performance of a long operation attended with shock, and the proper assistance and surroundings could be secured. When much hemorrhage was probably taking place, however, it should be done earlier than otherwise.

Among the contra-indications were profound shock, unless this was due to hemorrhage. He thought that by no means every physician was competent to perform laparotomy, and that, as rule, a case would do better if left to nature than if operated on by an incompetent surgeon. Experience was a prerequisite in this procedure; and, if possible, only one pair of hands should be allowed to enter the abdominal cavity. Acute peritonitis or wounds of other organs besides the intestines, he thought, might prove contra-indications.

THE VALUE OF EXPLORATORY OPERATIONS—Mr Thomas Bryant has recently given an address on the exploratory operations in the practice of surgery. These operations are of value for *diagnostic* as well as for *curative* purposes. To cut into a growth the nature of which can only be told with certainty after an incision into its substance, and which, if of a cancerous kind, cannot be too early removed, is a scientific, conservative and sound proceeding. To apply this practice to tumors of the mamma is most essential, and it has saved many a breast. In diseases of the testicle it is hardly necessary to point out the wisdom of a like practice. Many cases of hematocele have been mistaken for mal-

ignant affections, and have been removed unnecessarily. In diseases of the joints it would be well if the operation of excision were, as a rule of practice, preceded by an exploratory incision. If this were done, it would be frequently found that no excision would be required, but by making a free vent for discharge, or by removing a piece of necrosed bone, the joint might be left to itself and a better result obtained than would have been produced by excision. In abdominal, renal, vesical and pelvic surgery, the value of exploratory operations is best shown. Suppose a surgeon is called to see a patient with every symptom of acute strangulation of the intestine, while there is no external evidence to verify the diagnosis. Is he to wait until symptoms turn up, or to set about an exploratory abdominal incision at once? The author decidedly considers that an incision should be made, and that the case should not be left for the effect of drugs to be watched, or for further symptoms to show themselves. By making an incision, one will find out the cause of the strangulation; perhaps a band is present; or there is an internal hernia; or a volvulus; or an intussusception. Again, should an acute peritonitis be present, and its cause obscure; should a deep-seated abdominal or pelvic suppuration exist, and its true position only guessed at, then an exploratory operation is the best thing that can be done for the patient. Several cases are mentioned, but the following will illustrate how important it is to perform an operation in these obscure cases. A girl, aged 11 years, was suddenly taken ill November, 1884, with high fever, furred tongue, and an intense pain in the right iliac fossa. She was attended by Dr. Hubbard, and recovered sufficiently to get up and run about, but similar attacks occurred during the next nine months. In October, 1885, another attack occurred, associated with pain and tenderness, more in the right lumbar than the iliac region. When Mr. Bryant saw the patient on October 17, he was certain that there was deep-seated pus somewhere, and decided to operate. Next day an incision, above and behind the crest of the right ilium, evacuated two or three ounces of fetid pus, and with it came a puff of wind. The abscess was supposed to have some connection with the cecum; the opening was enlarged downwards in front of the anterior iliac spine so that the cavity could be washed out with iodine water and a drainage-tube put in. After this the fever abated, but the abscess would not heal. Some two months later Mr. Bryant was probing the wound and thought he felt a hard body. On January 26, 1886, a hardened orange pip passed from the sinus, and in three weeks the child was well. In cases of *chronic*

obstruction medical treatment should have the first place, so long as no local cause can be made out by rectal examination; but when a stricture is detected, the line of treatment is to operate. Many cases, however, are met with in which every symptom of mechanical obstruction is present, but because digital examination of the rectum fails to find the exact seat of the obstruction, the operation of colotomy is put off and then usually the case ends rapidly from a perforation taking place. It is in these cases that Mr. Bryant strongly condemns the practice of waiting, and insists on an exploratory incision into the right or left lumbar region, according to circumstances, to give the patient relief by a colotomy, when minor measures have been tried without relief. The author here describes a marked improvement in the operation of colotomy, by a method he has adopted in twelve cases during the last two years. It is only applicable where there is no great urgency for the operation. Having divided the abdominal parities, with the oblique incision, and exposed and caught the bowel, a knuckle of intestine is brought out by a careful loosening process, and fixed *in situ* with two long hare-lip pins with flat heads, introduced through the integument forming the upper lip of the wound. The ends of the pins are covered with cork; even if the intestine be full of feces or flatus, nothing escapes where the pins are passed. The whole wound is then washed in iodine water, and plenty of iodoform (one part) and boric acid (three parts), finely powdered, is thrown in with a puff-ball. The wound is now stitched up in front and behind the projecting bowel, leaving an opening for drainage at the posterior angle, into which a strip of iodoform gauze is inserted if the patent is thin, but if fat a drainage tube is used. The whole wound is then covered up with iodoform gauze dipped into a mixture of terebène (one part) and olive-oil (three parts), a good sheet of Gamgee tissue and a bandage fixing the whole together. On the third, fourth, or fifth day, when the bowel has become perfectly adherent to the outside parts, the pins are removed and the bowel laid open. If the soft parts about the pins ulcerate, these should be taken out sometimes as early as the second day; but, even if this is necessary, it will be found that sufficient adhesions have formed to prevent the bowel from falling back. The author considers the operation of enterotomy applicable to cases of strangulation in which the risk of laparotomy is rejected as being too hazardous, or where, on account of the age of the patient, any severe measure must be set aside; to cases of abdominal obstruction in which the clinical evidence points to obstruction high up in the colon, or low down in the small intestine; to cases in

which laparotomy is inapplicable and colotomy is out of court; to cases of obstruction in which relief is urgently required, and a more exact method of giving it is not clear, either from some difficulty of diagnosis or some other cause. It is an operation which often gets a patient as well as the surgeon out of a perplexity, and is not difficult. Exploratory operations in cases of suppuration of the kidney, in cases of suspected renal calculus, or in examples of growth in or about the kidney, are of somewhat modern origin, and have been crowned with great success. In cases of suppurating kidney the author states he has not yet been tempted to excise that organ, and believes it is only necessary in very exceptional cases. The lecture concludes with a few remarks on operations on the cranium and its contents. Recent observations have proved that in *exceptional* cases a diagnosis of a tumor can be made with sufficient accuracy to justify a surgeon in cutting down upon and trephining a skull in search of a tumor with a view to its removal; but it has not been proved that these operations can be performed without great risk, nor can considerable portions of brain be removed without injury. In the Guy's Hospital Reports for 1886, Dr. Hale White has published an analysis of 100 cases of cerebral tumor with reference to operative treatment, cause, mode of death, and general symptoms; it would be well for every surgeon to carefully study this analysis, to give ballast to any judgment which might otherwise possibly be over-stimulated by the brilliant successes lately achieved by Professor Victor Horsley. — *Quar. Comp. Med. Sci.*

A PRACTICAL HINT ON THE PERFORMANCE OF TRACHEOTOMY.—Upon looking through various text-books and articles upon this operation, I can find nowhere any insistence upon the following detail—one important, as I believe, at any rate to operators of not large experience, and valuable, as increasing greatly the facility and therefore the success, of the operation. The operator is usually recommended, standing preferably on the right side of his patient, after first determining the exact relation of parts, to fix the trachea with the left hand, the fingers on one side and the thumb upon the other, at the same time stretching the skin at the site of incision. The direction is at least distinct, but the manipulation is usually in effect very different. In all of many cases which I call to mind there has been a little (the only) trouble in the operation, and in some considerable danger, delay, or anxiety, consequent upon the way in which the attempt is made to keep the windpipe steady, as customarily

taught and performed: four fingers on the left side and the thumb upon the right side of the larynx, press with more or less force immediately backward to hold the organ in place, with the effect of considerably aggravating the dyspnea (especially if an anesthetic is not being employed), of flattening the pipe against the vertebral column to some extent, of in all cases increasing the depth at which the part to be incised can be reached, and frequently of failing to secure fixity of the larynx, which, likely to move with the slightest change of pressure, is pushed still more out of reach by the increased pressure made to secure it. Any or all of this inconvenience is the result of pressing backward with the finger placed upon the skin immediately on either side of the windpipe. The suggestion I have to make, and which, I have no doubt, many surgeons have long ago thought of or adopted, although hitherto I have never seen it noticed, is so simple as to provoke a doubt as to its value, but any one who tries it will, I think, find it so effectual in practice as to have no more doubt than I have as to its advantage. Let the surgeon place his left hand, as widely expanded as possible, over the neck of a child in the position for tracheotomy; then, resting the fingers upon one side, and the thumb upon the other firmly upon the skin, as far to the side of the neck as they will reach, gradually draw in the thumb and fingers, and the skin (and loose tissues underneath) with them, toward the median line; as the sides of the windpipe are approached, a little more pressure, made in a backward direction, will place the ends of the thumbs and fingers in a position in which they almost meet behind the larynx, which is thus firmly held by the encircling hand in a position in which all the great blood-vessels, etc., (which *have* been wounded) and the vertebral bodies (which, it is recorded, have *blunted a knife-point*) are far out of harm's way, the windpipe itself starting forward and standing out prominently under the skin, which is yet fairly stretched (and can be stretched more tightly) over the site of incision, and lying both as superficially as could be desired and as perfectly under control as possible. Lastly, and this I think is not altogether unimportant, this procedure may be adopted without producing more than the very slightest degree of discomfort in any ordinary child—the younger the more easily—and one is still able to make the skin as tight as possible; now, however, the necessary pressure is distributed all round, instead of acting directly backward upon the tube so as to flatten or displace it. I have even been able, without much trouble, to make the thumb and fingers feel each other behind it by this means; while, by the older method, I have seen

the production of undoubtedly a dangerous increase of dyspnea. I may have overrated the danger, or underrated the utility of the usual method of fixation, but it has always seemed to me to be the only difficulty in an operation, which of course has none for experienced surgeons, but to others presents often some trouble, chiefly in consequence of the fact that the means adopted for fixing the part to be incised, being ill-devised though time-honored, are not only not to be relied on to secure that end, but, as I have tried to show, they directly tend to increase the depth of the wound of the trachea from the surface and the distress of the patient; and in all the accidents I have read of, and some that I have witnessed, this method has shown itself marked sometimes by danger, often by inutility. *Leonard Braddon, F. R. C. S. E., London Lancet.*

ELECTROLYSIS IN STRICTURES OF THE URETHRA.—The following rules are given by Dr. Newman for the guidance of those who use this treatment (*Medical Record*):

1. Any good galvanic battery which has small elements and is steady will do.
2. The fluid for the battery ought not to be used too strong.
3. Auxiliary instruments, as galvanometer, etc., are important to the expert, but not necessary to the beginner.
4. For the positive pole a carbon electrode is used, covered with sponge, moistened with hot water, and held firmly against the cutaneous surface of the patient's hand, thigh, or abdomen.
5. For the absorption of the stricture the negative pole must be used.
6. Electrode bougies are firm sounds insulated with a mass of hard-baked rubber; the point is a metal bulb, egg shaped, which is the acting part in contact with the stricture.
7. The curve of the bougie is short; large curves are mistakes.
8. The plates must be immersed in the fluid before the electrodes are placed on the patient, and raised again after the electrodes have been removed.
9. All operations must begin and end while the battery is at zero, increasing and decreasing the current slowly and gradually by one cell at a time, avoiding any shock to the patient.
10. Before operating, the susceptibility of the patient to the electric current should be ascertained.
11. The problem is to absorb the stricture, not to cauterize, burn, or destroy tissues.

12. *Weak currents at long intervals.*
13. In most cases a current of six cells, and from two-and-a-half to five milliamperes, will do the work, but it may be regulated according to the work to be done.
14. The seance should be at intervals not too frequent in succession.
15. The best position for the patient to assume is that which is most comfortable for himself and the operator—erect, recumbent, etc.
16. It is best to avoid anesthetics, so that the patient can tell how he feels.
17. Force should never be used; the bougie must be guided in the most gentle way; the electricity alone must be allowed to do the work.
18. Two electrodes in succession should never be used in the seance.
19. All strictures are amenable to treatment by electrolysis.
20. Pain should never be inflicted by the use of electricity; therefore, it should not be used when the urethra is inflamed.

AN EASY METHOD OF PLUGGING THE POSTERIOR NARROWING OF THE URETHRA. *Therapeutic Gazette*, Dr. Haynes, of Philadelphia describes a method of treatment of persistent epistaxis, as follows.

A piece of fine silver wire, fifteen inches long, is used. One end is left rounded, and the free ends are twisted together. A slight bend is given to the bar thus formed. A piece of wire, one inch long, is tied to the twisted end.

The patient sits in front of the physician. The wire is applied backwards, so as to make the passage of the wire easy. The parts are illuminated by the light of a lamp. If it is found that the wire is not passing, it may be used.

The wire is then used to plug the posterior narrowing of the urethra. The wire is then used to plug the posterior narrowing of the urethra. The wire is then used to plug the posterior narrowing of the urethra.

finger, or anything else convenient. The thread is cut, and the wire is then used to plug the posterior narrowing of the urethra. The wire is then used to plug the posterior narrowing of the urethra. The wire is then used to plug the posterior narrowing of the urethra.

mouth ends of the thread are tied together, so as to form a loop, which is hung over the nearest ear, 'out of the way.

The anterior nostril is then obstructed, if necessary, by means of a mass of cotton, which will readily stay in place.— *Michigan Medical Review*.

ON A NEW METHOD OF PERFORMING EXCISION OF THE KNEE JOINT. Mr. H. Allingham read a paper on a new method of performing excision of the knee joint, before the Medical Society of London. The joint was opened by a long vertical incision, and the patella divided into two lateral halves, which, together with the soft parts, were slipped to the sides of the joint; the crucial ligaments having been divided, the joint was firmly flexed, and a slice removed first from the femur, and then from the tibia; the lateral ligaments were not divided. The whole surface of the joint, and the synovial pouches, were then cleared of synovial membrane; the patella, if only slightly diseased, was scraped, and the two halves brought together and sutured; if much diseased, it could be shelled out of the entire quadriceps tendon without destroying the connection of the muscle with the ligamentum patellæ, and the split tendinous expansion, together with the split ligamentum patellæ could be brought together with catgut sutures. Drainage tubes were inserted through suitable posterior counter openings, and the wound closed with separate sutures. The operation must be performed with antiseptic precautions. Mr. Allingham claimed that by this procedure the joint was more thoroughly opened to inspection at the operation: that dislocation of the tibia backwards after the operation was prevented; that the undivided quadriceps antagonized the hamstrings; that progression was better for the same reason, and that the prospect of obtaining movement was greater.

THE VITELLINE MEMBRANE OF A HEN'S EGG AS A MATERIAL FOR CLOSING OPENINGS IN THE MEMBRANA TYMPANI.— Dr. F. Berthold (*Archives of Otology*) after many experiments, found that openings in the membrana tympani could be readily closed by covering them with a piece of the vitelline membrane of a hen's egg. Of course all such procedures suppose that all inflammatory disease of the middle ear has been cured. Then he proceeds as follows: A piece of the vitelline membrane, its outer surface presenting, is taken up with a curved drop tube, a slight suction being sufficient to render it adherent to the orifice of the tube. It is then trimmed to the desired size and shape, and brought in contact with the membrana tympani. Slight pressure upon the rubber bulb of

the drop tube will suffice to cause the gluey surface of the egg-skin to adhere to the edges of the perforation. It will remain in contact for weeks or months.—*Detroit Lancet*.

THE CURABILITY OF CANCER BY OPERATION.—Dr. Geo. F. Shrady, the talented editor of the *Record*, thus concludes a valuable paper on this subject :

1. Cancer is essentially a local disease, and can be cured by operation in spite of recurrence.
2. Operation, when it does not cure, prolongs life and diminishes the total amount of suffering.
3. Operations should be repeated as often as there is any chance of entirely removing recurrent growths.
4. The earlier and the more thoroughly the operation is performed the better.
5. The disease, when it recurs, is generally of a milder type than that of the original growth, less painful and less exhausting.
6. Antiseptic surgery makes more radical operations possible, with better ultimate results, than formerly obtained.

TO DETERMINE THE COMPOSITION OF A CALCULUS.—Dr. James Tyson gives the following directions (*Boston M. and S. Journal*) :

Powder the stone and apply heat. If it disappears, it is in all probability uric acid, or compounds of uric acid. If there is any doubt, the murexide test* may be applied. If the stone does not disappear upon being incinerated, it is composed either of phosphates or of oxalate of lime. If it is the triple, or ammonio-magnesian phosphate, the application of heat to a piece of the original stone will melt it into a bead ; if it does not melt, it is either phosphate of lime or oxalate of lime. If it is oxalate of lime, the incineration will convert it into carbonate of lime, which, in acetic acid, will dissolve with effervescence ; if it is phosphate of lime, it dissolves without effervescence. Thus, with very little trouble, we may, with sufficient accuracy for practical purposes, ascertain the composition of a calculus. The bases are not ascertained, but this is not necessary.

DIAGNOSIS OF TUMORS OF THE BLADDER.—At the French Congress of Surgery M. Guyon made a statement concerning the diagnosis of

* Place a little of the powdered calculus on a plate and dissolve with nitric acid. Apply heat until the acid is evaporated. Add a little solution of ammonia, when, if it is a uric acid stone, a beautiful purple color will appear at the point of contact.

tumors of the bladder. This diagnosis may be arrived at by studying the symptoms. Hematuria is a very important symptom on account of the time it lasts, its frequent recurrence, and being easily provoked by simply passing a bougie. This fact permits the distinguishing between a tumor of the bladder and a tumor of the kidneys. Tumors of the kidneys are recognized by the increased size of the kidneys, their mobility, the concomitant varicocele frequently observed, and the cylindrical clot, peculiar to hematuria, and colic is a symptom. A neoplasm in the wall of the bladder is ascertained by examining the rectum and the bladder. Passing a catheter does not reveal the presence of a tumor, but in certain cases may afford valuable indications. It has been suggested that perineal incision should be employed in order to ascertain exactly the spot to which the new formation is attached. [M. Guyon does not recommend this method, and considers that intervention should only be made in cases where new formation causes complications, cystitis, retention of urine, or any kind of disturbance in the urinary function. In these cases it should be rapidly affected. M. Guyon prefers operations in the hypogastric region rather than in the perineal. He employs red hot irons on the lower part of the bladder. He affected eighteen operations on fifteen patients, and discovered thirteen malignant and two benign tumors.—*Det. Lancet.*

THE DIAGNOSIS OF RUPTURE OF BLADDER.—The importance of an early diagnosis of rupture of the bladder, when intra-peritoneal, is very great, in view of the fact that upon prompt interference depends almost certainly the life of the patient. Dr. Robt. F. Weir, of New York (*Med. Record*), recommends the introduction of a Peterson's bag into the rectum (the bladder of a pig or other animal will answer as well), and the injection into it of seven and one-half ounces of warm water. This will distend the rectum and elevate the bladder. The line of supra-pubic flatness is then determined, and outlined by a colored pencil. Seven or eight ounces of antiseptic fluid are next injected into the bladder: if a rupture exists this fluid will pass into the peritoneal cavity; but otherwise the line of flatness will be elevated, and the fluid injected may all be recovered.

COLUMBUS MEDICAL JOURNAL.

EDITORIAL.

Heating and Ventilating.

The connection of the heating of a house with its ventilation is, of course, inseparable. Many persons will cheerfully expend ten or fifteen thousand dollars in building a house, putting from two to three thousand on outside ornaments, who would not dream of spending five hundred or one thousand dollars for the necessary Hot Water Apparatus to keep this same house thoroughly and comfortably warmed and well ventilated.

In reading the reports from the various Boards of Health, one can not fail to notice the startling increase in the death rate from Scarlet Fever, Diphtheria, and allied diseases. It might safely be said that this condition of affairs is due to the fact that the tightly closed doors and windows, which cold weather makes necessary, prevents the ventilation of houses, which is essential to the maintenance of health.

To those who intend erecting a dwelling, we would advise that the matter of heating and ventilating be given much consideration; and before deciding how it shall be done, consult the A. A. Griffing Iron Co., Manufacturers of the Tompkins Hot Water Indirect Radiator, 520 Communipaw Ave., Jersey City, N. J.

Fluid Forms of Hydrastis.

The reputation of this drug as a therapeutic agent was first gained through its employment in the form of an *infusion*; and in the fifty years following its introduction into medical practice, a continuous effort has been made by manufacturers to perfect a preparation which would represent all the active principles of the drug, without the high price of the salts, either alone or in combination.

The most prejudiced writers on *Materia Medica*, accord to the late Wm. S. Merrell the largest share of credit in the introduction of Hydrastis preparations, and to the present organization the reputation of being the *largest consumers of the drug in the world*. For more than a half-century, Hydrastis has been made a study in our laboratory, and we do not think we exaggerate its importance when we assert that it stands pre-eminent to-day as the most valuable exponent of our vegetable *Materia Medica*.

The following preparations in *fluid form* are receiving our special attention at this time:

Fluid Hydrastis—MERRELL.

Is what its name implies—the active, medicinal principles of the drug in natural combination and in a fluid form. It has a bright, yellow color, perfectly clear, free from sediment, and with an unmistakable odor of the *fresh drug*.

Fluid Hydrastis is a pure, neutral solution of all the alkaloidal constituents of the drug, rejecting the oil, gums, irritating and offensive resins and inert extractive matters. The success attending its introduction is the best evidence of its therapeutic value.

Unsuccessful imitations and would-be substitutes are met with on every hand. Preparations said to be “just as good” or “about the same thing,” but always “a little cheaper,” attest the wide-spread and growing popularity of Fluid Hydrastis. All such, compared with the latter as to physical appearance or as representatives of the drug, *are condemned*; dispensed in prescriptions, *they are readily detected*; tested therapeutically, they are *promptly rejected* as unworthy of confidence.

Fluid Hydrastis is applicable to the treatment of all irritable, inflammatory and ulcerative conditions of the mucous tract.

This statement of a well-known medical writer and journalist has become axiomatic:

“No remedy for physician's use has been received with such universal approval.”

Solution Bismuth and Hydrastia—MERRELL.

An invaluable and scientific combination, wherein the beneficial action of the white alkaloid is increased by association with Bismuth. This solution contains $2\frac{1}{2}$ grains of the double Citrate Bismuth and Hydrastia; twenty-five per cent. of which is Hydrastia Citrate.

The cordial reception accorded this preparation marks it as the most valuable combination in the market in which the white alkaloid alone represents the valuable properties of the drug. Used in diseases of the nasal passages, of the eye, of the throat, of the stomach and intestines, of the reproductive organs and bladder it is equally beneficial.

Colorless Solution of Hydrastia—MERRELL.

This is a permanent solution of the white alkaloid, without the addition of any other medicinal agent to modify or increase its action. It is offered without special recommendation to meet the views of an unlimited number of physicians, with whom the color of the Fluid Hydrastis is an objection. This solution contains in one fluid pint the same proportionate strength of white alkaloid as exists in an average quality of crude root.

See notes above on Solution Bismuth and Hydrastia.

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HANN & ADAIR, Publishers, Columbus, O.

OHIO State Sanitary Association, at the Neil House, Columbus, Feb. 10th and 11th.

HOUSE HEATING.—For small houses, especially in the country where the air is essentially free from soot, the ordinary hot-air furnace is probably the simplest, cheapest, and most satisfactory means of supplying heat. The thrifty contractor, however, usually puts in a furnace that is too small, i. e., one that must be kept too hot in order to warm the rooms in cold weather. The cold air duct and the hot-air flues are also usually too small. The aim should be to have an apparatus that will furnish a large amount of warm air, instead of a small amount of hot air.

For large residences, especially in the cities where the air is soot-laden, the furnace is unsatisfactory, at least as usually arranged, and the choice must practically lie between steam and hot water. With steam, the cracking, banging and pounding which occur in the morning as steam enters the pipes, when one is just enjoying that delicious period between sleeping and waking, are only exceeded in disagreeableness by the same sleep-murdering sounds at the other end of the day, as the pipes cool off; while the constant "fizzing" from some unfortunate valve renders the day wretched, especially to nervous old ladies, and the rust stains on carpet and wall are by no means equivalent to high-art decorations. The pipes are at 212°, or cold; if the fire gets low, the steam goes down; if too high, the blowing from the safety valve adds its increment of noise and confusion; if too much water gets into the boiler, no steam will form, while too little will likely result disastrously. Most

of these objections can be overcome, in *theory*; but in practice our picture is not overdrawn. In a large public building, having a competent engineer, steam may be made to work admirably; but in a private residence, where the servant girl is the engineer, the reverse will be the rule.

With hot water, on the contrary, there is no noise either on heating or cooling; there are no valves to leak; the boiler is always full; the radiators can be kept cool, or warm, or hot, as desired; and no engineering skill is needed to run it.

The first cost is about the same, but the running expense and wear and tear with hot-water are less than with steam. The writer has had the hot-water system in use in his house and office for five years, and is much pleased with it. Since it was put in, however, many improvements have been made in such heating apparatus, especially in the matter of radiators. Then there was no proper radiator in the market; we were obliged to have our radiators cast, at our risk, from patterns devised by ourself and made under our direction. Now, however, the demand has increased, and radiators that are cheap, neat and efficient, can be secured for hot-water as easily as for steam. Among the various patterns, however, we know of none that meets all the indications so well as the modified Bundy, which we have advertised for over a year. The manufacturers are experts in this method of heating, and will cheerfully impart any desired information.

ANNUAL OF THE UNIVERSAL MEDICAL SCIENCES.—This is the title of a new publication to be issued early in 1888, having for its object to present a report of the progress of every branch of medicine, during the year, in different parts of the world. "Corresponding Editors" have been appointed in foreign countries who will furnish the editorial department, here, an outline of all new facts. This information, added to that obtained from journals, new publications and other sources, will be placed in the hands of "Associate Editors," chosen among the most eminent men of this country, who will write the final sections of the work. Efforts will be made to investigate the methods employed by uncivilized races to treat disease, in the hope that some valuable remedy or procedure may be discovered. Dr. Charles E. Sajous, of Philadelphia, is the Editor-in-chief. There will be about one hundred and fifty Corresponding Editors; and sixty-four Associate Editors. The work will consist of five royal octavo volumes, of about five hundred pages each, fully illustrated with wood-cuts, colored plates and maps.

Among the gentlemen who have accepted Associate Editorships we find the following: Loomis, J. Lewis Smith, Delafield, Otis, Seguin, Munde, Stimson, Keyes, Spitzka, Ranney and Delavan, of New York; Richardson, Draper and Minot, of Boston; Davis, of Chicago; Conner and Whittaker, of Cincinnati; Senn, of Milwaukee; Hamilton, of Washington; McGuire, of Richmond; Guiteras, of Charleston; Gihon, of U. S. Navy; Pepper, Agnew, Goodell, Parvin, Leidy, Holland, Dunglison, Cohen, Tyson, Van Harlingen, Shakespeare and Garretson, of Philadelphia.

The price of the "Annual" will be \$15 per set, per year, free of express charges.

The plan of this work, as above outlined, cannot fail to result in the production of an exceedingly valuable work. The plan is unique, and the editor has laid out for himself an immense amount of work.

OZONE.—Comparatively little attention seems to have been given to ozone during the last ten years.

In a paper written on this subject thirteen years ago (*Amer. Jour. Med. Sciences*, Oct. 1884), we concluded with the two following paragraphs:

"When I commenced the study of this subject, I was biased in favor of the view that ozone could produce disease directly by its presence, and indirectly by its absence. But after a careful and candid investigation, I think this view entirely erroneous. Reasoning *a priori*, from the premises furnished by what I found known of ozone and of epidemics, did not result in a conclusion favorable to any such hypothesis; while a resort to recorded observation proved no more satisfactory. It is true that occasionally, in some circumscribed locality, the fluctuations of an epidemic have seemed to sustain a certain relationship to the fluctuations in the amount of ozone; but such an exception proves nothing. In truth, it would be strange if such a coincidence did not sometimes occur; for, by a well-known law, a parallelism must exist, now and then, between two independent and irregular curves.

"In the relation of ozone to disease, that which accords perfectly with the known properties of ozone, which harmonizes with the results of all observations, and which at once challenges rational belief, seems to be simply this: *ozone influences the general health, only so far as it purifies the air by destroying*—not the living germs of disease, but—*the products of decomposition*. Beyond this, all views concerning the action of ozone, as a cause, a remedy, or a preventive of disease, rest upon vague and unfounded hypothesis."

Dr. Debierre, in *Nouveaux Remedes* (translated in *Buffalo Med. and*

Surg. Journal), brings the same subject up to date, and his conclusion, practically identical with our own, is as follows:

"On the whole, we may conclude that ozone possesses very feeble, if any, therapeutic powers; that ozone, if inhaled or swallowed, cannot enter the blood as such, and even if it could, but little harm and no good would be done.

"The only use for ozone is to purify the air by combining with decomposing organic matter. It is not a bactericide, but atmospheres richest in ozone are purest."

Dr. J. C. Reeve, of Dayton, reports in the *Phil. Med. News* a case of sudden death from the introduction of an aspirator needle, the operation being done without an anesthetic, for abscess of the liver.

"This case is not unique in medical records, yet it is one of deep interest, and especially in regard to the action of anesthetics. It is useless to speculate upon what might or might not have been done. I cannot, however, abstain from expressing one or two convictions. First, that under full anesthesia this man would not have died at the time and in the manner that he did. Second, that with *partial* anesthesia, his death would have occurred as it did, and gone to swell the list of casualties from anesthetics. He evidently died from inhibition of the heart's action, the impulse being transmitted from the puncture. The mode of death was precisely similar to those which have occurred from tooth drawing under chloroform when movements of the patient, etc., were proof that the anesthesia was not profound."

The *Cleveland Med. Jour.* thinks that Cleveland would have contributed more to the advancement of medical science and literature if it had maintained a local medical journal. This is unquestionably true. But if the profession had quarreled less, and devoted itself more unselfishly to the study and development of medical science, it would always have had a medical journal, and numerous active medical societies. In so far as we have been able to understand the case, homeopathy has got its great hold there because of the intestinal quarrels of men prominent in the regular profession. A house divided against itself cannot stand. We are glad to welcome the advent of conditions favorable to the strengthening of the regular profession of Cleveland. The success of its excellent journal will be an index of continued and increased prosperity.

—*Detroit Lancet.*

WE note with pleasure that the publication of the *Ephemeris* has been resumed by Dr. Squibb. It would be difficult to find a journal

which contains so much valuable matter in so unpretentious a form. The number just issued contains, among other matters, information on the extent to which cocaine has come into use. Dr. Squibb alone has, since October, 1884, made and sold seventy-six and a half pounds of the alkaloid, using in the process about twenty-two thousand three hundred pounds of leaves. The price has fallen from \$1.25 to 1½ cents per grain.

THE *Annals of Surgery*, published in St. Louis, is devoted exclusively to surgery, as its name indicates. It is the only periodical of its kind in existence, and its articles are all of the highest quality. It is a journal that every progressive surgeon should take.

THE case of Dr. Darby, for refusing to serve the State as an expert gratuitously, we understand will come up next in the district court. If the decision there is favorable to the Doctor, he will of course carry it no further; but if otherwise he will take it to the Supreme Court. In that case it will be several years before the final decision is reached.

PASTEURIANA.—Statistics show that 47 out of the 2400 treated by Pasteur are known to have died, and the percentage of deaths from hydrophobia in France has not been in the least altered by his methods.

Dr. R. H. Reed, of Mansfield, has tendered his resignation as surgeon of the Pennsylvania company at that place, which took effect January 15th. The position required no small amount of labor and responsibility and only gave a pass in no.

At the recent centennial celebration of the founding of the College of Physicians, of Philadelphia, ten physicians were deemed worthy of the honor of Honorary Fellowship, among them being two from Ohio, namely Dr. J. C. Reeve, of Dayton, and Dr. J. T. Whittaker, of Cincinnati.

OBITUARY.—J. M. Wheaton, after an illness from consumption of about two years, died Jan. 28, at his residence in this city, aged forty-six years. Dr. Wheaton graduated from Starling Medical College in 1864 and immediately went into the army as an assistant surgeon. At the close of the war he began practice in this city. He was Professor of Anatomy in Starling Medical College, a trustee of that institution and Government pension examiner at this point. Aside from his professional merits, he was a naturalist of the highest order and the leading ornithologist of the State. He was also well posted in entomology and geology,

and was employed by the State Geologist to write the report on the birds of Ohio, which appears in the report of the geological survey. This report is recognized as the most complete ever published on this subject. Dr. Wheaton had the finest and most complete collection of stuffed birds in Ohio.

Quiet and unobtrusive, Dr. Wheaton was the soul of honor and a consistent churchman. A wife and a boy nine years old are left to mourn the loss of a devoted husband and a loving father.

NOTES AND COMMENTS.

UNUSUAL CAUSE OF DEATH.—The French public was recently agitated by the discovery of the dead body of a genteel girl in a sequestered street in the suburbs of Paris. There were no marks of violence, but no doubt was entertained, either by the police or the public, that the death was due to crime. For some days the journals were full of wild theories as to the motives which might have prompted the murder. The real circumstances of the case, as now ascertained, are a trifle less romantic, but are sufficiently curious, from several points of view, to merit a passing remark.

At the post-mortem examination, which was made in the usual course of events at the Morgue, it was discovered that death was due to suffocation caused by impaction in the larynx of a collection of the *Ascaris lumbricoides*, which the child had presumably vomited, but not ejected. Not the least remarkable feature in the case is the explanation offered by the parents of their conduct in the matter. Terrified by the sudden death of the child, which nothing had foretold or could explain, they had preferred depositing the body in an unfrequented spot, to risking the malicious remarks and innuendoes of the neighbors and that dread official, the *concierge*. Rather than face this, and a possible trial for manslaughter, they, in a fit of desperation, resorted to the reprehensible plan which excited so lively an interest in French society. The cause of death is one which deserves to be recorded in the annals of legal medicine.—*Phil. Med. News*.

[Several years ago, in this city, a colored woman suddenly complained of strangling, thrust her fingers into her throat and drew out a long round-worm. A few weeks later, she was suddenly seized as before, but failing to get hold of the worm fell to the floor and died.—J. F. B.]

ABSENCE OF ILL RESULTS FROM CONSANGUINEOUS MARRIAGES IN JAPAN.—An interesting contribution to the study of consanguineous marriages occurs in the paper of Dr. Baelz on the Japanese, in the *Sei-I-Kwai*. He says: "Near the bathing resort, Atami, there is situated a small island named Hatsushima. The inhabitants of that island, nearly three hundred in number, have for more than two hundred years exclusively married amongst themselves; strange blood has never entered the island. Those people live by fishing, and from the proceeds of a small trade with the neighboring coast. They are physically and mentally quite normally developed, and their statistics show a larger number of births, and a smaller number of deaths in proportion than any other part of the Japanese empire."—*Phil. Med. News*.

A NEW HYBRID.—Before the St. Louis Medical Society Dr. Funkhouser exhibited a specimen of an embryo five days old, the result of the union of a rooster and a duck. This was the only fertile specimen of sixteen such eggs hatched in an incubator. The doctor thought his experiment tended to upset prevailing ideas about species, general orders, and classes. All sources of error with regard to the roosters and ducks had been carefully avoided. He regarded it as an extraordinary event that a member of the order of swimmers, being crossed with the order of scratchers, should have produced a living result, thus jumping over not only species, but also further. The duck and the rooster are of the same class, but belong to different orders.—*Phil. Med. News*.

TO KEEP THE HANDS SOFT.—

R	Ol. rosæ.....	gtt. xv
	Glycerinæ.....	3 j
	Sp. myrciæ.....	f 3 iiij
	Ol. cajuputi.....	gtt. xx

M. S.—To be used on the hands every night before going to bed; and in cold weather to be applied before going out into the open air; the hands being first washed and dried.—*Med. World*.

LIQUID GLUE.—Fill the vessel (glass) with the best broken up glue, and fill up with acetic acid. Keep it in hot water for a few hours until the glue is melted, and you will have a most excellent glue always ready.—*N. E. Med. Monthly*.

THE LOWEST TEMPERATURE ON RECORD.—Dr. C. W. Suckling reports in the *Lancet* the case of a woman dying from myxedema, whose temperature the day before ranged from 66° F. to 76° F. The pulse was 36; respirations, 12.

TEST FOR BILE IN URINE.—Chloroform, as a test for bile in the urine, is ready, delicate, and certain. All that is necessary is to agitate a few drops of it in a test tube, along with the suspected urine. If bile be present, the chloroform becomes turbid and acquires a yellowish hue, the depth of which is in proportion to the amount of bile present in the urine. If no bile be present, the test-fluid remains limpid.

SHARPENING HYPODERMIC NEEDLES.—A fruitful cause of abscesses in hypodermic medication is dull and rusty needles. The rust may be avoided by wiping the needles from time to time with rouge or crocus cloth, purchasable from any cutlery or hardware establishment. The finest emery cloth is too coarse for this use. Every physician ought to be able to sharpen his needles himself. The best hone for the purpose is that known as the Hot Springs or Washita razor hone. Thrust the needle with the wire in it, through a bit of soft velvet cork long enough to come within a quarter of an inch of the commencement of the bevel point of the instrument. The cork will serve as a handle for the fingers and at the same time holds the needle stiff and taut. It is also a guide in preserving the proper bevel of the point. A few light rubs upon the hone will put a keen point on the dullest needle.—*St. Louis Med. and Surg. Journal*.

MIXTURE FOR CLEANING GREASE SPOTS.—Equal parts of stronger ammonia water, ether, and alcohol form a valuable cleaning compound. Pass a piece of blotting paper under the grease spot, moisten a sponge, first with water to render it "greedy," then with the mixture, and rub with it the spot. In a moment it is dissolved, saponified, and absorbed by the sponge and blotter.—*Scientific American*.

A SIMPLE TEST FOR ARSENIC IN WALL-PAPER.—A simple and easily-applied test for arsenic in wall-papers has been devised by Mr. F. F. Grenstedt. No apparatus is needed beyond an ordinary gas-jet, which is turned down to quite a pin-point, until the flame is wholly blue; when this has been done, a strip of the paper suspected to contain arsenic is cut one-sixteenth of an inch wide, and an inch or two long. Directly the edge of this paper is brought into contact with the outer edge of the gas-flame a grey coloration, due to arsenic, will be seen in the flame (test No. 1). The paper is burned a little, and the fumes that are given off will be found to have a strong, garlic-like odor, due to the vapor of arsenic acid (test No. 2). Take the paper away from the flame, and look at the charred end—the carbon will be colored a bronze-red, this

is copper reduced by the carbon (test No. 3); being now away from the flame in a fine state of division, the copper is slightly oxidised by the air, and on placing the charred end a second time, not too far into the flame, the flame will now be colored green by copper (test No. 4). By this simple means it is possible to form an opinion, without apparatus and without leaving the room, as to whether any wall-paper contains arsenic, for copper arseniate is commonly used in preparing wall-papers. Tests 1 and 2 would be yielded by any paper containing arsenic in considerable quantities.—*Brit. Med. Jour.*

REVIEWS AND BOOK NOTICES.

Manual of Differential Medical Diagnosis. By Condict W. Cutler, M. S., M. D., Physician to the New York Dispensary; Assistant Surgeon to the New York Hospital, out door department; late House Physician to Bellevue Hospital, etc. 16mo., pp. 161. New York and London, G. P. Putnam's Sons, 1886. Columbus:—A. H. Smythe. Price, \$1.25.

In this little manual the author contrasts the symptoms of diseases that are most likely to be confounded with each other, choosing such symptoms as will most readily lead to a correct diagnosis, and limiting himself to those that afford the most striking contrast. The book is an excellent one for one so small, and will be appreciated by those who have not time or facilities for reference to larger works.

Diseases of the Nerves, Muscles and Skin, being Vol. III. of Dr. Hermann Eichhorst's Handbook of Practical Medicine, and Vol. X. of Wood's Library of Standard Medical Authors, 1886 (consisting of 12 vols., price \$15.00). Sold only by subscription. William Wood and Company, New York.

It is unnecessary to speak in particular of this volume. In excellence it fully equals the volumes that preceded it, of which we have spoken in terms of high praise. The number of illustrations is unusually large.

The two series of articles, "How I was Educated," and "Confessions" of members of several religious denominations, which have attracted a good deal of attention in the *Forum*, are to be followed soon by two other series. In one of these will be presented the views of many different schools of thought, as the Agnostic, the Evolutionist, the Positivist, as well as those of Christian theology, Protestant and Catholic,

upon the question, "What is the Object of Life?" In the other, many of the most notable men of the day will contribute instructive and interesting chapters out of the history of their own lives, under the title, "Books That Have Been Useful to Me."

Vick's Floral Guide is by far the handsomest seed catalogue that is issued in America. It is handsomely bound, and contains illustrations enough of flowers and vegetables to make the amateur gardener crazy.—Address: James Vick, Rochester, N. Y.

How to Work with the Microtome, and a method of demonstrating the tubercle bacillus. By James E. Reeves, M. D., of Wheeling, W. Va. Price, 50c. Rochester, New York. Bausch & Lomb Optical Co., 1886.

This is an intensely practical *brochure* for all who work with the microscope. Its author is not only well known as an expert in microscopy, but in the *technique* of staining, cutting and mounting, he stands without a superior and with few rivals.

An Epitome of the Newer Materia Medica. Fourth edition. Revised and enlarged. Parke, Davis & Co., Detroit, Mich., 1886.

This epitome embraces not only the new drugs but also the standard medicinal products and fine pharmaceutical specialties introduced and manufactured by Messrs. Parke, Davis & Co. It contains a full property and dose list of all their extracts, German tinctures, normal liquids and concentrations, and the formulæ of their pills.

This enterprising firm has added so much to our *Materia Medica* that is new and valuable, that the busy physician feels the need of some book like this for quick reference. A copy, in paper covers, will be sent *free* on application.

The Healing of Arteries After Ligature in Man and Animals. By J. Collins Warren, M. D., Assistant Professor of Surgery, Harvard University; Surgeon to the Massachusetts General Hospital; Member American Surgical Association; Honorary Fellow Philadelphia Academy of Surgery. One Volume. 184 Pages. Superbly illustrated with Twelve Full-page Plates in Black and colors. Parchment Muslin Binding. Price, \$3.25. William Wood and Company, New York.

This is the most thorough work, on this important subject, that we know of. The author is entirely competent to undertake the task, and he has worked out the problems with most pains-taking care. The plates are unusually fine.

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COMMUNICATIONS.

THERMOMETRY.

BY STARLING LOVING, M. D., COLUMBUS, O.,
Professor of Theory and Practice of Medicine, Starling Medical College, from a
Lecture delivered in Starling Med. College, Dec. 22, 1886.

The discovery by Wunderlich, in 1851, of the value of the thermometer in diagnosis, prognosis, and management of acute diseases has exercised as much influence in the direction of scientific accuracy and intelligent therapeutics as any discovery of the present century, and though appreciated and applied, there is room for belief that the limits of its usefulness have not been reached, and that further investigation may develop new fields from which valuable additions to existing knowledge may be gathered.

Until it was demonstrated how infallibly the thermometer determines the febrile state, the medical profession had no certain standard by which to estimate the intensity or even the existence of fever. They were obliged to depend on the acuteness of the sense of touch, which varies so much with atmospheric and other conditions; upon symptoms of one or another kind which have not uniformly the same significance and which are not always present; but mainly upon the increased frequency, and other qualities of the pulse. It is therefore not possible to

obtain an accurate estimate of the temperature of the body by sense of touch unaided, nor to judge the febrile state by the pulse alone. With the thermometer the physician approaches the bedside with perfect confidence in his ability to determine without chance of error, not only whether his patient has fever, but its intensity, and often its type as well. More than this, after a few observations he is enabled to predict with much accuracy the termination of many cases by the temperature alone, leaving out of consideration much formerly considered of first importance in prognosis. The thermometer enables us also in great measure to estimate the importance of sudden changes which so frequently occur in the course of acute diseases, as typhoid fever, pneumonia, acute rheumatism, etc. The student should, therefore, in the beginning of his studies, make himself thoroughly familiar with the use of the instrument and the deductions to be drawn therefrom.

He should first secure from a reliable source an instrument which has been properly tested and graduated. It is easy to obtain one here or in Europe, with a certificate of correct reading attached. One should be selected with the "lens," or "prismatic face," so that the column of mercury can be seen with ease, even in a poor light, and with a long rather than a short tube, that there may be less trouble in handling. Should there be any doubt as to its correctness he had best throw it away and buy another.

Having satisfied himself as to the quality of his instrument, the student next learns how and when to use it. After ascertaining that the registering column of mercury is not above 98.5° , the bulb of the instrument may be placed in the mouth, in the armpit, in the fold of the groin, or in the rectum.

If the mouth be chosen, the bulb of the instrument may be placed between the tongue and jaw, on either side, or outside, between the teeth and the cheek, and the patient directed to close his lips around the stem, and breathe exclusively through the nose. The mouth is an objectionable surface for the reason that even though the lips remain closed during the entire examination, its temperature changes somewhat during each respiratory act. Colder air is inspired and warmer expired. Again, many patients, children and adults, are restless, or impatient, and can not be induced to keep the lips closed, while some are delirious and may break the thermometer with their teeth, and possibly suffer injury. Added to the uncertainty and difficulty of obtaining correct reading of the temperature by the use of this surface is the repugnance naturally felt by patients

to the introduction of instruments which have already been used into their mouths, and the possible danger of conveying contagion, as of syphilis, or other disease. The axilla, consequently, is a better locality, and has the further advantage that it is nearer the central portions of the body. Before applying the instrument it is well to notice the position of the arms in relation to the body. If one arm is close to the side and the axilla closed, while the other is extended and the armpit exposed to the air, that which is closed is of course the warmer, and should be selected because it will give the speediest results. After the skin has been dried with a soft cloth, the bulb of the thermometer should be pushed closely into the armpit, and the arm should then be drawn against the chest, the forearm flexed and carried across the body, so that the hand may grasp the arm on the other side. Should the patient be very weak, delirious, or insensible, the arm may be held in position by the nurse. Flexing the arm shuts the axilla, and completely encloses the bulb of the instrument, while the upper portion of the stem is free and exposed to the air. It is common for the physician, or the nurse, after placing the thermometer in the axilla, to draw the clothing over the shoulder as it was at the beginning of the operation. By such course an amount of heat is retained, and the result of the test will be somewhat unreliable, consequently the upper end of the tube should always be left exposed. Should the patient complain, the clothing may be arranged so as to cover all except the surface immediately around the instrument.

Should circumstances render it desirable or necessary to use another locality, the bulb may be placed in the fold of the groin, or between the thighs, which should be crossed, or pressed together, so as to enclose the bulb as it is enclosed in the axilla by flexing the arm. When the patient is a child, or an adult male, there is no reason why the groin may not be used, but, as when the thermometer is applied to the rectum, or to the vagina, as recommend by some, patients, especially females, now and then object on the score of indecency; and most students and practitioners will agree that there is sufficient ground. The groin affords no advantage over the armpit.

Decency apart, owing to the great difference which often exists between the temperature of the surface and that of the interior of the body, the rectum is the best surface for thermometrical observations, and necessity will sometimes cause the student to disregard all considerations except that most important at the time. There are a few diseases, as pneumonia, scarlet fever, and measles, in which there is little or no

difference between the temperature of the internal and external parts of the body, and the thermometer may be applied to any surface, even between the toes, with correct results, but in most other maladies the fever heat is not so evenly distributed. In some, as in Asiatic cholera, there is a remarkable difference between the heat of the skin and that of the interior of the body. While the thermometer will mark 97° F. and below when applied to the skin in a case of cholera during the stage of collapse, the mercury may rise to 105° when the bulb is passed into the rectum. Great difference is sometimes observed in typhoid fever, and in acute peritonitis also; therefore, when accuracy is desirable, it is necessary to select a locality as near the centre of the body as possible.

The time required for a complete observation varies considerably. When the skin is hot, as in case of remittent fever, or one of measles, three or four minutes will suffice; but when the surface is not so warm, as is often the case, a perfect register cannot be obtained in less than ten minutes; and some maintain that fifteen, and even thirty minutes are required. As has been stated, there are conditions under which it is impossible to find the true temperature by testing the external surface of the body.

The thermometer should in no case be withdrawn in less than five minutes, and it had better remain longer, say ten minutes. The "busy practitioner" will object to the consumption of so much time, but it must be borne in mind that thermometry is of little value unless properly applied.

When the thermometer has been withdrawn, and before registering the result, the student should recollect that the normal temperature of the body, owing to age, sex, differences of temperament, idiosyncrasies, the taking of food and drink, the time of day, and the climate, varies somewhat, but that the physiological variations are all within narrow limits. There is some difference of opinion as to the exact limit. Flint, jr., states that it varies between 97.7° and 99.5° Fahrenheit. Dr. Davy fixes it at 98° F. Dalton at 100° (rectal temperature). Foster at 37.6° Centigrade. Hermann, between 36° and 38° Centigrade. Loomis, between 97.5° and 98.4° F. Other writers place the normal temperature at 98.4° and 98.6° F., and the range as between 98° and 99.5° F. A safe average is 98.6° F. Ninety-nine and five-tenths is the upmost limit of normal heat, and that degree is so seldom reached in the physiological state that it is considered as sub-febrile, and is so classed by Wunderlich, and others following his classification, which has not been improved in

any essential particular. Then 99.5° F. and above to 100° F. and 101° , is sub-febrile heat. Below, it becomes sub-normal. Sub-normal temperature is not common. It is not observed except in conditions of extreme depression and exhaustion of the nervous and vascular systems, from the shock of injury, profuse hemorrhage, from starvation, or from some disease which rapidly exhausts the vital powers by overwhelming the nervous system, or through great increase of secretion, as pernicious fever and Asiatic cholera. It should not be forgotten, however, that in those diseases, while the temperature of the surface is below the natural standard, that of the interior of the body may be much above.

Subnormal temperature is perhaps oftenest observed in the beginning of convalescence from some of the acute and inflammatory diseases, as typhoid fever, and pneumonia. When noted in connection with the ordinary indications of return to health, it is not to be regarded as unfavorable. But a sudden fall of temperature during the second or third week of the course in a case of typhoid fever from 103° , 104° and above to 100° , or 99° , and below, generally indicates hemorrhage from the bowels, or perforation; rarely, it means that the disease has terminated by crisis.

Abnormally high temperature on the other hand is a feature of the greater number of acute diseases, of whatever type. One hundred and three-tenths to 101.4° , is slightly febrile. One hundred and three-tenths degrees, morning, and 102° , evening, indicates moderate fever. When there is decided fever, the thermometer will indicate 103.1° , in the morning, and 104° in the evening. When 103.1° in the morning and 104.9° in the evening is registered, there is high fever. Hyperpyretic temperature is 106° and above. "Paradoxical" temperature is 107° , and above, to 112° — 122° , and is occasionally observed in tetanus, surgical injuries involving the spinal cord, fevers, and in hysteria. Such temperature does not necessarily, as was formerly thought, indicate uniformly a fatal event. On the contrary it is sometimes evanescent, and may occur in trifling affections.

When the temperature remains at 104° and above, the case has become dangerous. When it reaches 105° and above and remains, there is very great danger. If it remains at 105° and above for any considerable period, the case, whatever its nature, generally terminates in death. The catastrophe is frequently averted by prompt and judicious application of remedial measures, but persistently high temperature, even though no more than 104° , is always to be regarded with apprehension. However,

a temperature of 105° , or even 106° , may prevail for a short time, and not indicate great peril. It is not uncommon to observe the temperature at 102° , or 103° , in the morning, and 104.5° or 105.4° in the evening in children suffering from acute bronchitis, catarrhal pneumonia, and sometimes even when the disease is much less serious, as in acute indigestion. Sensitive, nervous women, and men also, frequently have excessively high temperature without adequate lesions. In the other direction, in the diseases of aged persons, the temperature is apt to be below what we expect, taking the range in adult life as the standard.

Excessive temperature, long continued, is of itself sufficient to destroy life, leaving out of question the disease or injury which has been its cause.

It has been stated that a persistent temperature of 106° or 107° is "hyperpyretic," or above febrile. Such heat is not frequently observed, and it is well known that a lower degree, 105.5° , is above the danger line. It is therefore wisest to consider that "hyperpyrexia" begins at 105.5° , and to govern treatment and prognosis in accordance with that fact.

In febrile diseases, as in health, though constantly above the normal standard, the temperature has in a measure the same variations. That is, it is lowest in the morning—the minimum being reached about six o'clock. From early morning it gradually rises and reaches the maximum in the evening, between six and eight o'clock, when it begins to decline, and the minimum is reached again in the early morning. This goes to show that the same influence, that of the sympathetic action of nerves, controls the temperature of the body in the febrile as in the healthy state, but that its power of control, though not destroyed, is weakened.

Exceptions to what has been stated in regard to the "temperature curve," or "diurnal variation," are not unfrequently observed, and such are often highly important in a diagnostic view. Thus, if in a case of fever the temperature is highest in the morning, and lowest in the evening, the malady is probably malarial in character. If, during the progress of an attack of rheumatism, bronchitis, or pneumonia, there occurs a considerable elevation at about the same hour every day, there is a strong malarial element, which must be overcome before much benefit can be expected from special treatment.

During health there are oscillations of temperature arising from exercise, greater activity of function, the taking of food, mental changes, and other circumstances. The alterations are not very great; the oscil-

lations are of short duration, and have no special significance; but unless it be remembered that such may occur at any time, a record of temperature made from frequent observations may prove unsatisfactory.

In the management of a case of disease the temperature may be taken as often as may be desirable. Frequent observations are sometimes necessary in critical cases, but, in ordinary cases of febrile, or inflammatory affections, morning and evening is sufficient.

The record may be made upon a "temperature chart," such as may be bought almost anywhere, or, preferably, upon a plain piece of paper, the figures for observations made at different periods being placed in separate columns under the appropriate hours.

The Fahrenheit thermometer is almost exclusively used in the United States and England, but some prefer the centigrade or Celsius, the common instrument of German scientists. To convert the degrees of the centigrade scale into the corresponding value for the Fahrenheit scale, multiply by 1.8, and add 32 to the product.

COCAINE INEBRIETY.—The use of cocaine to excess in persons who have never used alcohol or other narcotic drugs before, is very rare. Among inebriates and drug maniacs, cocaine inebriety is no doubt increasing. Its peculiar dangerous effects on the body will prevent its general use as an intoxicant to any great extent. It acts more rapidly than opium, but its effects pass off more quickly. Its first effect is more exhilarant than alcohol, but it is uncertain and variable. This stimulant action develops mania, followed by narcotism and melancholia. When given in cases of melancholia in large doses, it changes the case to mania, then finally relapses bringing back the case to melancholia again. As an intoxicant it is more dangerous than alcohol or opium. As a form of inebriety it is more difficult to treat, requiring a longer time to break up, because of the physical and psychical complications. It cannot be used as a substitute for any other narcotic, or as an antidote or remedy.—Editorial in *Qr. Jour. of Inebriety*.

PROF. HEIDENHAIN, of Breslau, says that our ideas about the functions of the cerebrum are about as clear as "shoeblacking."

OBSTETRICS.

BREECH LABOR : CERTAIN POINTS IN THE CONDUCT OF THE SECOND STAGE.—(Dr. J. C. Sanders in *Med. Era.*)—The mortality in breech labor rests almost exclusively in the child, and this fatality depends on conditions that conspire in the progress of the second stage.

First:—As soon as the hips become engaged within the os, involving as this does the close approximation of the thighs of the fetus to its body, the umbilical cord becomes subject to pressure, by being caught between the child's thighs and body. This condition of peril continues on and attends the delivery of the breech through the brim, excavation, outlet, and even the grasp of the vulvar orifice. *Second*:—As soon as the shoulders engage the os, the cord is submitted to pressure between their circumference and the inner margin of the os, and the presence of the arms flexed upon the chest might intensify as their extension upwards upon the sides of the head might relieve this pressure, by the extended arms making a kind of a bridge over the cord. *Third*:—When the shoulders are delivered from the grasp of the os, the cord become imprisoned between the circumference of the head and the inner margin of the os not yet dilated sufficiently for its prompt exit, because the smaller end of the ovoid has been delivered first. The compression exerted at this juncture would be considerable only during a pain. *Fourth*:—The compression of the cord becomes greatly aggravated, indeed reaches its greatest possibility, when the head, either still in utero, or ex-utero, is wedging the cord beneath the head's circumference and the inner surface of the brim, or between it and the planes of the excavation, or between it and the marginal grasp of a firm or rigid vulva. *Fifth*:—When the head is detained in utero from lack of sufficient dilation on the part of the os, the placenta itself becomes speedily subject to compression, at every pain, between the uterine walls and the dome of the head, a compression sufficient to compromise the safety of the child. *Sixth*:—The last pain that expelled the head from the uterus, or the next that follows, and before the head is delivered from the pelvis or vulva, may detach the placenta and thus cut off the maternal current of life before birth has become completed or after completion. Before respiration has become established the child is very prone to perish.

The great sources of peril to the child may be resolved into three :

First:—Compression of the cord. *Second*:—Compression of the placenta. *Third*:—Detachment of the placenta, prior to completed

birth. In the face of these specific dangers, the great indication of successful management consists in securing to the child the greatest possible immunity, by reducing to the minimum these dangers, so far as they are unavoidable, and conversely, so far as they are avoidable, to avoid them. In fulfilment of this general indication there are cardinal points of conduct, often unappreciated or unheeded, that are essential to the safety of the child. They may be summarized as follows: *First*:—The diagnosis having determined a breech labor, the forceps should be sent for, if not already at hand, and made ready for instant use as the labor approaches its close. *Second*:—The position in which the breech is presenting should be promptly ascertained, since this must control the decubitus of the mother, at the close of this stage. If the breech presents, however, in either first or second position, that is, in either of the sacro-anterior positions, the mother's decubitus is not so important; she may be on her back or side, at the discretion of the obstetrician, or as may be most agreeable to her. But if the breech presents in either of the sacro-posterior positions, her decubitus from the time that the perineum comes to be appreciably pushed against, invariably must be on her side, left or right. The child would probably be lost by any attempt at delivery in either of these sacro-posterior positions, were the mother permitted to remain on her back. *Third*:—In the course of the second stage, as opportunity shall best offer, the attention of the mother should be drawn to the fact that there will come a time when, whatever her inclination may be to the contrary, she shall obey the command of the obstetrician, as he shall challenge her to bear down with all her might. Her pledge to this should be secured, as this voluntary force may be most needed when she is the least inclined to exercise it, and just this supplemental force may be essential to the safety of the child. *Fourth*:—The delivery of the breech should not be aided or hastened by art, except, always of course, when art is demanded for the safety of the mother, or when art is demanded to overcome some obstructive condition, as in case of failure to engage the brim by reason of extraordinary bulk of breech, or failure to make the necessary rotations after engagement. With these exceptions the rule should be inviolate, whatever the tediousness or delay, whatever the importunity of the patient, or the clamor of the helpers or sympathizers, or whatever the pressure of business engagements on the hands of the obstetrician. This is one of the keys to the problem of safety. This rule unviolated, secures to the soft parts the greatest possible dilatation, and furnishes thereby the best possible preparation for the

speediest delivery of the head, after the body and shoulders of the child have escaped. *Fifth*.—In case the presentation is in either of the sacro-posterior positions, that is, the third or fourth, as soon as the hips have escaped from the verge of the vulva, the breech should instantly be seized by the hand, and in the interval that now generally ensues, be pushed upwards and backwards and rotary motion imparted to the hips, so as to secure the necessary rotation of the shoulders and head, but in case no interval ensues, all further descent of the breech should be firmly resisted, and an interval is thus made to succeed, when the rotary manipulation instantly should be instituted. This consists, in case it is the third position, in carrying the hips from the antero posterior position into a sharp left obliquity, that will oblige the shoulders to rotate from their now right obliquity into left obliquity and the vertex pole of the occipito-frontal diameter, into right obliquity, and thereby engage the brim corresponding to the right acetabulum, thus converting the third into the second position, so that the delivery of the head shall be effected as if the breech had presented in the second position. In case of the fourth position, the hips are to be carried into sharp right obliquity, obliging the shoulders to engage the brim in right obliquity, and the vertex pole of the occipito-frontal diameter to revolve from the left sacro-iliac juncture forward, so as to engage with the vertex at the left acetabulum, converting the fourth position, so far as the delivery of the shoulders and head is concerned, into the same as if the breech primarily had presented in the first position.

The successful conversion of these sacro-posterior positions immensely conserves the safety of the child. Failure in these conversions involves great disadvantages, which may be stated thus: (*a*)—Loss of space dependent on the ill adaptation of the face and forehead as compared with the center curve of the vertex, to the concavity of the symphysis and pubic arch. (*b*)—The co-adaptation of the face of the child against the immovable inner surface of the symphysis, occluding thereby to a greater or less extent, and often completely, access of air to the mouth and nostrils of the child. (*c*)—The sharp spasmodic retraction of the perineum over and upon the back of the neck of the child, sometimes and often making difficult the displacement of the vertex backward sufficiently to permit the face to be brought down promptly enough to save the child. These disadvantages may make all the difference between loss and rescue; whereas, with the face to the hollow of the sacrum, as in the first and second, or the converted third and fourth positions, the perineal

floor may be pushed back so as to give access of air to the mouth and nostrils, and thus make respiration possible before the head is delivered from the grasp of the vulva or even from the outlet. *Sixth* :—As soon as the hips are delivered and their rotation when necessary effected, the limbs of the child quickly and carefully should be brought down, so as to take off all tension on the umbilicus and giving it a position so as to be relieved to the greatest extent possible from pressure by the descending body and rotating shoulders, and the breech of the child be supported in the direction of Carus' curve extended, which in the first or second position, or the converted third or fourth, will carry the body of the child, as the shoulders become delivered, up over the symphysis, toward and upon the abdomen of the mother. But having failed in the conversion, or having been called too late to effect it, in case the breech is presented in the third or fourth position, the movement of the breech and body of the child must be the reverse of this : they must be carried backward over the perineum and towards and upon the back of the mother, in order that, as the shoulders become delivered, the mental pole, which leads, may be born first, and the face of the child displaced backwards from the inner surface and arch of the symphysis, so as to give access of air to the mouth and nostrils, and make respiration possible anterior to completed delivery. *Seventh* :—The necessary rotation of the shoulders at the outlet, and of the head at the inlet, and the bringing down of the arms, should next demand prompt attention. The bringing down of the arms is a nice little art and should always be conducted with a movement from the vertex towards the chest of the child, that neither arm may become locked over the back of the neck and thus embarrass the rotation and descent of the head. *Eighth* :—With the arms brought down and the shoulders delivered, the head of the child is in the excavation, presumably escaped from the uterus, but not necessarily so, since there may not have been attained a sufficient dilatibility of the os to permit the head yet to escape, or there may not be a sufficient *vis a tergo* to compel its expulsion from the uterus. If escaped from the uterus the uterine forces have no more power over it to effect the completion of delivery, and even if not escaped the uterine forces are so inconsiderable as not in any degree to be trusted or relied on, as at all helpful to completion of birth. *Ninth* :—The completion of birth after the head has become engaged within the excavation, depends almost exclusively on the voluntary forces and the interposition of obstetric art.

These special duties are here immediate and imperative: *First* :—

To challenge the voluntary powers, the mother bearing down with all her might, agreeably with her pledge. *Second*:—To adjust the cord where it will be least pressed upon. *Third*:—To make traction through and upon the neck of the child so as to keep the centre of the head to the line of Carus' curve and forthwith complete the delivery. But whatever the dispatch, obstetric art inviolably must obey three cardinal rules: *First*:—The chin must be kept to the chest, for it leads and must be born first. *Second*:—The necessary rotations of the head must be secured. *Third*:—The integrity of the soft parts must be respected. Any haste that would drag the chin from its flexion on the neck and chest would incur the liability of locking it upon one or another of the salient points of the outlet or on the perineum; or that would disrespect the rotations that the head must make, would entail a fatal delay; or that would disregard the integrity of the soft parts would add greatly to blunder. The chin may be kept from departing from its flexion on neck and chest by the application of the first and second fingers of the free hand upon the chin, one on either side, or passing the hand a little higher by their action on the superior maxillary, one finger on either side of the nostrils, or even by one finger inserted inside the mouth; never here however for traction; never, for traction is to be exclusively exerted upon and through the neck, but used only to keep the chin down on the neck. No defacement of the child or harm to the symphysis of the lower maxillary can result from this manipulation thus limited. The necessary rotations of the head may be secured, if not spontaneous, by manipulations with the body, acting on and through its neck, supplemented, if necessary, by pressure exerted by the fingers of the free hand on one side or another of the chin or face. The integrity of the soft parts is to be conserved by protecting them from incurring any mechanical disadvantages in the dispatch that may be deemed necessary to the safety of the child. The amount of tractile force justifiable on and through the neck of the child, with the chin held down and the head's rotation secured, is far beyond the average estimate. Experience in forceps delivery, with the head leading, wherein the traction is often chiefly spent on the child's neck, and is sometimes carried to the limit of the strength of the obstetrician's arm or hand, and this, too, with perfect safety to the child, furnishes abundant proof of the truth of this proposition. I have no doubt that many a child has been sacrificed by the timidity of the obstetric art, at this precise juncture in the conduct of breech labor. Indeed it would be difficult if not impossible to exert a force endangering

the child, simply by the one hand and arm that grasps and engages its body, chest, and shoulders, for the other hand has largely to be engrossed in keeping the chin down, properly placing the cord where it will be least subjected to pressure, securing the necessary rotations of the head and keeping back the perineal floor from the face of the child, if in the first or second position, or in keeping the face from the inner surface of the symphysis, if in the unconverted third or fourth position. A force, then, within the limit of one hand and arm to exert, may be considered safe and justifiable, so far as tension on the neck of the child is concerned, and such a force of traction may be counted on as sufficient for the completion of delivery in every case, except in preternatural narrowness of the pelvis, and except in certain cases where there is an extraordinary firmness or rigidity of the vulvar and perineal structures as to prove too resistful to the escape of the head. In such cases the forceps become necessary to supplement what tractile force within this limit fails to accomplish, or when a force beyond this limit is demanded. When required they are as imperatively required as the life of the child is sacred. If the child be dead, as evidenced by the cord having long ceased to beat, the forceps may be dispensed with, for an intermitting traction, in imitation of nature's process of gradual dilatation, will ordinarily soon accomplish the delivery; but if alive, as evidenced by the cord still beating, however feebly, our only hope will depend on an immediate forceps delivery. If there is a doubt as to its life, our duty is to give the child the benefit of the doubt and immediately deliver. Not to have the forceps ready and at command in face of such a peril to the child is nothing less than an inexcusable and criminal neglect.

The propositions that underlie these last mentioned rules of duty merit the emphasis of repetition: *First*:—From the time the head of the child enters the excavation, the completion of its birth is exclusively dependent on the voluntary forces of obstetric art. *Second*:—The voluntary forces are, however, only a moiety of what is necessary to prompt delivery. *Third*:—The completion of birth is chiefly dependent on obstetric art. *Fourth*:—Obstetric art in order to be conservative to the life of the child, must be intelligent, energetic and prompt. To rely on the uterine forces to complete the birth, after the head has escaped from the uterus, as it generally has by the time the head comes down into the excavation, or to rely on these, even in case the head has not fully escaped, but is so far escaped that only its dome is still retained, and this only by the engrasping of the os around and below the parietal

eminences, is a deceiving expectation and only a waste of golden time; or to trust the voluntary powers for the accomplishment of completed delivery, when at best these aggregate only about 1-6 of the labor forces necessary to carry the head through the outlet and over the perineum to a successful issue, is alike illusory and involves an imperiling delay; or to wait on the slow processes of gradual dilatation in the transit of the head is a no less dangerous procrastination.

THERAPEUTICS OF FEMALE STERILITY.—The rational treatment of female sterility is based upon a knowledge of its causation. In anemia, chlorosis, or scrofulosis, reconstructive medication is required. Amenorrhea, if the generative organs are normal, may yield to local stimulating applications, such as scarification of the cervix, introduction of the sound or of stem-pessaries, vaginal douches, hot foot or sitz-baths, galvanism or faradic electricity; aided by aloes, apiol, or permanganate of potassium used internally. In the amenorrhea of corpulent women, Kisch, Martin and Rohrig extol the sulphate-of-soda waters, among which those of Marienbad have a high reputation. In this country the waters of Crab Orchard Springs in Kentucky, Bedford Springs in Pennsylvania, or Ballston Spa in New York, would probably be equally efficacious.

In endometritis, applications of tincture of iodine or of iodinated collodion to the internal surface of the uterus are often effective. When villous endometritis is present, or the uterus still contains remnants of a previous misconception, the dull curette is indicated. In peri or parametric exudations, hot-water vaginal douches and iodoformized tampons are useful.

Catarrhal diseases of the vagina must be treated with astringents. Kisch reports a case in which there were profuse hyperacid secretions. He directed injections of a fifteen per cent. solution of sugar to which one-tenth per cent. of caustic potassa had been added. In this solution the spermatozoa remain active for a long period. The woman became pregnant after using this injection for some time. Charrier found in two similar cases that the daily injection of a solution containing one part of albumen, with fifty-nine of phosphate of soda, in ten thousand of water, removed the acidity of the secretion, and the women conceived in the course of six weeks, although during four years of married life they had been sterile.

Gonorrhea should be treated with germicide irrigations. The most effective are nitrate of silver (one to three thousand—one to two thous

and), salicylate of sodium (one to twenty), corrosive sublimate (one to twenty thousand).

In atrophy of the uterus the galvanic and faradic currents may be used with some hope of benefit.

Vaginismus demands a careful consideration of each case. Recently cocaine in four per cent. solution painted on the vulva and vagina has been found effective. If this fail, operative measures (dilatation under anesthesia and subsequent wearing of a plug) may be resorted to.

In cervical stenosis dilatation with tents or incision may be employed. The former method is warmly advocated by Schultz. If rigid instruments are used, the solid round dilators of Peaslee or Hegar should be chosen. The dilating instruments which act by a separation of two or more blades are by Kisch considered inappropriate. In hypertrophy of the cervix, amputation is proper; in laceration, Emmet's operation.

Atresia of the vagina does not demand treatment in the absence or defective development of the other internal generative organs.

Displacements should be appropriately treated by manual reposition and pessaries or tampons.

The accepted opinion among physiologists is that the most favorable time for conception is two or three days before the beginning, or five or eight days after the cessation, of the menstrual flow.

Kisch does not advise attempts at the artificial impregnation of the human female, as practised by Sims and some of his followers. He closes his very interesting monograph with the caution to the physician not to be too ready to give either a favorable or an unfavorable prognosis. In the former case he may be mistaken and disappointment follow; in the latter he may likewise err, and his judgment will then be discredited in other things.—*Phil. Med. Times.*

THE RELATION OF VERSION AND EXTRACTION IN POINT OF TIME.—Winter, from the material of the Royal University Clinic in Berlin from 1876 to 1874, collected 310 cases of simple, uncomplicated, transverse positions of full term living children, and has come to the following conclusions:

1. The teaching that version and extraction should not be performed in immediate succession, arose from the supposition that the footling case produced artificially by version has the same prognosis as the same presentation occurring naturally.

2. The earlier and generally adopted practice of performing ver-

sion as soon as possible after the escape of the liquor amnii rests on the fear of the intra-uterine death of the fetus, and especially of the increased difficulty of version after longer waiting.

3. Fetal death does not occur alone from the premature escape of the liquor amnii, but also when tympanites uteri, unduly powerful pains, or tonic uterine contractions complicate the case.

4. Version cannot be rendered difficult by waiting until the dilatation of the os, for the dangerous thinning of the lower uterine segment does not occur until the expulsive stage; nor, again, does the clonic uterine contraction cause trouble in turning. Tonic uterine contraction, however produced, is a pathological condition, which is always to be avoided.

5. In normal cases children bear version and immediate extraction with safety.

6. Waiting after version before proceeding to extraction is very dangerous to the child, which often dies in utero, or is saved by speedy extraction.

7. The causes of fetal deaths are injuries to the cord during the version, separation of the placenta, and entrance of air into the uterus.

8. Whether the membranes are ruptured or unruptured, version should not be performed until the extraction can be immediately proceeded with.

9. Only a definite indication, such as placenta previa, prolapse of the cord, beginning of infection, imminent asphyxia of the child, great thinning of the lower uterine segments, pure inertia uteri, demands early version, that is, before the dilatation of the cervix, and then for the most part in the interests of the mother.—*Boston Med. and Surg. Jour.*

ANESTHETICS IN OBSTETRICS.—Dr. J. P. Davidson (*New Orleans Med. and Surg. Jour.*) draws the following conclusions:

1. When chloroform is given judiciously and in moderate quantity it does not lessen the uterine contractions; and whenever the anesthesia is carried too far, the cessation, or inertia, should be ascribed to the abusive use of the agent.

2. There is strong reason to believe that, unless complete anesthesia is produced, the abdominal muscles continue to aid by their contraction the expulsive efforts of the uterus.

He does not believe that chloroform judiciously administered exerts

any decided prejudicial effects upon the mother's health, yet because the improper use of the anesthetic, in women who flow abundantly, might give rise to trouble, he advises, as a matter of safety, a dose of ergot immediately upon delivery, to secure efficient contraction of the uterus. He has never seen any bad effect of chloroform upon the life and health of the child.

At the meeting of the N. Y. State Med. Society, Dr. Fordyce Barker read a paper entitled: "Is the Danger of Post-partum Hemorrhage Increased by the Use of Anesthetics During Parturition?" He expressed the opinion that no woman should die of post partum hemorrhage due solely to uterine inertia. He said the real question was, Did anesthetics, properly administered to relieve pain, increase the danger of post-partum hemorrhage? He had used chloroform almost exclusively since 1850, and he preferred it to ether because it was less irritating to the respiratory tract; the odor was more agreeable, a smaller quantity was required, its action was more rapid than ether, and it could be used intermittently. Chloroform oftener accelerated than retarded labor. Patients who had been sent to him because of their disposition to post-partum hemorrhage in former labors without anesthetics had done better under chloroform. The presence of heart disease did not contra-indicate its use. He agreed with Dr. Reeve that a close scrutiny failed to show that the judicious use of chloroform exerted an injurious influence on either the mother or the child. The only deaths from its use in obstetrics by competent practitioners had occurred in patients who had had convulsions. The speaker had had but one fatal case of post-partum hemorrhage, and in that case chloroform had not been used.

THE IMPROVED CESAREAN SECTION.—Dr. Garrigues (*Amer. Jour. Obstetrics*) strongly objects to calling this operation Sanger's. Indeed, the improvements which the cesarian section has undergone can be credited to no particular man. And perhaps Sanger, of those who have made practical improvements in the method, has the least right to lay claim to it as his own.

The following points are given as factors in producing the improved method:

1. The most important is the antiseptic treatment; Lister.
2. Early operation; Harris.
3. Turning of the uterus from the body before incising it, or immediately after delivery; Gueniot and Muller.

4. Insertion of a few sutures at the upper end of the abdominal wound to prevent protrusion of the intestines, and entrance of blood or foreign bodies to the peritoneal cavity; Frank.

5. A still better protection to the peritoneal cavity—the pushing of a piece of disinfected gutta-percha behind the uterus; Leopold.

6. Compression of the cervix by a rubber tube to prevent hemorrhage; Rein and Muller.

7. The application of soft cloths wrung out in a weak, warm solution of bichloride of mercury, to avoid shock from loss of heat; Wegner.

8. The uterine suture on which Sanger would base his claim to be the inventor of the improved Cesarian section. Yet, in the use of a number of small sutures he would seem to have been anticipated by Harris, Lungren, Baker, and others, and of the double sutures (deep and artificial), by Spencer Wells and Kehrer.

DELIVERY OF THE PLACENTA.—Dr. Hendrick recently read a paper before the New York State Medical Association, based upon his obstetrical experience as a country practitioner for 25 years and more. During this time he has never had a case of fatal hemorrhage. His method of dealing with the placenta may be obtained from this summary:

1. That efforts to deliver the placenta should be made within the first ten minutes following the close of the second stage, believing the vigorous uterus more responsive than at a later period.

2. That the application of the binder prior to the delivery of the placenta, except in inertia of the womb, and delay when the accoucheur could not remain by the side of his patient, is not only useless, but a hinderance.

3. That neither mode, of traction alone or expression alone, is the most efficient or desirable means of aiding in the delivery of the after-birth, but if either mode alone is to be adhered to, that of expression has the advantage over traction in being more efficient in completing this stage of labor, and also in preventing hemorrhage.

4. That the best method known is the proper combination of the two methods—traction and compression combined—keeping in remembrance that there is a vast difference between pressing the uterus and compressing or grasping.

5. Never neglect maintaining the firm grasp of the uterus for a period of some minutes following the descent of the placenta.

6. That the best treatment of retained placenta is not to have it—but, having it, to proceed with artificial delivery as soon as practicable; better use the most efficient means that can be deemed judicious than to leave the patient with the greater risks of hemorrhage, and a subject of adynamic and ataxic fever.

7. The best treatment of retained placenta in abortion is to “go for it” as promptly as possible.—*Prac.*

TREATMENT OF CANCERS OF UTERUS, WHEN TOO LATE FOR OPERATION.—Sarrante recommends, first, the sloughs should be thoroughly washed away with some antiseptic fluid. Two or three quarts should be used with a fountain syringe. After this any loose sloughs are picked away, after exposing the tumor with a speculum, and disks of absorbent cotton soaked in a 4 per cent. solution of chloral hydrate, and dusted over with iodoform, are spread over the tumor, or in the cavity if one has been formed. This treatment is applied three times a week. After eight months trial the following satisfactory results were obtained: •

1. Locally: the surface, which is formed at the beginning with putrid secretions and gangrenous tissue which it was impossible to detach, becomes clean after a few applications of iodoform, and has the appearance of an ordinary granulating wound, rosy colored and clean. It is more and more favorably modified as the treatment progresses.

2. From the beginning we have a complete cessation of pain, opiates being no longer necessary.

3. The treatment absolutely arrests all hæmorrhages. Watery discharges, it is true, continue, but diminish notably, and become thinner and less colored.

4. Finally, the general health becomes better, strength and appetite return, and the cachectic appearance disappears.

What effect this treatment has on the prolongation of life, cannot as yet be ascertained, but it, at least, allows these unfortunate persons to pass their remaining days in comfort, and they are no longer an object of disgust to those who surround them.—*Arch. of Gynecol.*

PUERPERAL CONVULSIONS.—Dr. T. Gaillard Thomas discussed this subject at the recent meeting of the N. Y. State Med. Ass'n, with special reference to the production of premature labor. He draws the following conclusions:

1. That, as we have a form of renal disease entitled desquamative nephritis, another due to blood poisoning of scarlet fever, and called

scarlatinous nephritis, so we have a third, which should be entitled puerperal nephritis, due to the condition of utero-gestation.

2. That puerperal nephritis is the great, if not the sole, cause of puerperal eclampsia.

3. That puerperal nephritis accomplishes this by leaving the blood surcharged with noxious elements which the crippled condition of the kidneys causes them to fail to eliminate.

4. That while we are ignorant of the method by which the puerperium induces this form of nephritis, we have abundant evidence of the fact that so soon as utero-gestation ceases to progress, the renal trouble, as a rule, diminishes, and soon disappears.

In answer to the query: Under what circumstances, in cases of threatened eclampsia, should premature labor be induced as a prophylactic measure? he said:

1. Every obstetrician mindful of his duty will invariably, after the third month of pregnancy, examine the urine up to full term at least as often as every ten or fourteen days.

2. If evidences of puerperal nephritis demonstrate their existence before the end of the seventh month, the period of fetal viability, every effort should be made by daily warm baths, the milk diet, laxatives, and the nightly use of bromides, to "tide the case over" until that period has been reached.

3. If the amount of albumen, tube-casts and epithelium be plentiful in the urine; if the secretion of urine be scanty; the patient complains of headache, dimness of vision, gastric disturbances, and all these symptoms do not at once diminish under the prophylactic measures already mentioned, we should not hesitate to bring on premature delivery at once.

4. Should the patient have passed through several pregnancies in safety, having at the same time presented the symptoms of puerperal nephritis; should the amount of albumin be moderate and the secretion free, with a good proportion of solid elements in it; should the evidence of constitutional disturbance be slight and the effects of prophylactic measures satisfactory, it would not be advisable to induce premature labor, but would be better to await the full term of gestation.

REFORM IN TREATING WOMB DISEASES.—Commenting on a synopsis of a paper read by Dr. Thomas Addis Emmet before the Obstetric Section of the late session of the British Medical Association, the *Va. Med. Monthly* says:

His experience is but an iteration of that of many worthy doctors in the ranks of the profession; but the continuous record of their self-learned lessons does not have a tithe of the influence in bringing about the reformation desirable as does the expression of opinion of an authority so eminent as Dr. Emmet. The "reform movement" has needed a leader, and we trust that Dr. Emmet will at once assume that position. The medical press should also lend the weight of its influence to aid in the corrections of errors of practice into which so many have fallen.

One who examines the armamentarium of the average *general* practitioner of the day, finding in the hand-pouch which he takes with him on nearly every professional round, scarcely aught else than the speculum, the sound, the dilator, the repositor, the iodine bottle and brush, the glycerine and oakum or cotton packing, a few pessaries of a favorite shape, etc., would naturally conclude that the womb, with its appendages, is looked upon as the "root of all evil" to which human flesh is heir. So open to abuse is such a teaching that we are not surprised to learn that the routine of the doctor's duty is thought to be accomplished when he places his patient in the dorsal or Sims' position, makes the digital examination, looks through his speculum, measures the depth of the uterus, "rectifies a mal-position," puts in a pessary, or dilates the os, applies iodine or other favorite remedy, packs with absorbent cotton wet with glycerine, speaks the hopeful word as to improvement, tells how busy he is, exhibits the pages in his visiting book to show how full they are, and makes a note to call a few days later to go through almost precisely the same routine. True, he has punched the abdomen, noted the "ovarian irritation," and prescribed for the leucorrhea. In fact, many a conscientious doctor feels that he has done his duty if he has done these things; he has done *secundum artem*; he has done what "the books" tell him to do, and he feels that the failure or success must rest as a responsibility upon the authorities.

Such is now the popular "uterine pathology" of general diseases which Dr. Emmet and others feel called upon to combat. If an exclusive doctrine as to the *fons et origo* of diseases is to be accepted, it were better, in our opinion, if the old teachings of Abercrombie were resurrected, and the stomach be again searched for the seat of the cause of all the aches and pains that afflict humanity. But if one truth has been developed by the advance of medicine more conspicuously than another, it is the fact of the general dependence of many of the so-called local diseases upon other pathological conditions than those to which our

remedies are, as a habit, chiefly applied. Hence the true specialist in medicine ought to first familiarize himself at least with the doctrine of the sympathies—the continuous, the contiguous and the remote—and their effects, as also with some of the elementary principles in physics.

In making this prominent mention of Dr. Emmet's paper, we wish to emphasize particularly the following points he brings out, which find confirmation in almost every day experience, and which ought to leave a lasting impression upon the minds of *general* practitioners :

1. That rare occurrence of most of the uterine displacements and non-puerperal womb diseases as prime *causes* of the so-called "diseases of women."
2. The common dependence of uterine diseases and displacements, leucorrhea, etc., upon morbid conditions *outside* the womb as a center.
3. The unimportance of uterine versions, stenosis, cervical erosions, etc., as pathological states.
4. Hence the discouraging results secured by dependence upon the repository, sound, dilator, local applications of iodine, etc.
5. Dependence must be put upon the treatment of the conditions outside the womb which cause these "womb diseases."

Dr. Emmet's allusion to the proper use of the pessary is valuable instruction to many. His statement that he has not so much as owned a sound for many months will "take the feather out of the cap" of some who boast of its utility. His better results since he adopted his present plan of procedure, will be information that will be gratifying to all who are seeking the cure of female diseases.

TO PREVENT MAMMARY ABSCESS.—Although Dr. Goodell ridicules the idea of aborting mammary abscesses, which he does not think can be done, yet Mr. Miall (*Brit. Med. Jour.*) says that when mammary abscess is on the point of forming, he has frequently seen all of the symptoms rapidly disappear in a few hours, under the influence of fomentations with hot water and carbonate of ammonia. He uses an ounce of the carbonate in a pint of water, and when solution is accomplished the temperature of the fluid will hardly be too high for fomentation to be commenced, with cloths dipped in the liquid. He applies them for from half an hour to two hours, at the same time protecting the nipples. He has often had immediate relief, and seldom requires to make more than three applications.—*Med. Abstract.*

ABDOMINAL TUMORS.—I wish now to make a few remarks on abdominal tumors. From 42 to 45 years of age women usually cease to menstruate, and this cessation may be abrupt or “dodging.” By dodging I mean that the menses, after being regular for two or three periods, will miss one or two, then recommence and intermit again, and so on. This “dodging” is the most usual course. But it is generally abrupt in those women who grow fat at this time, so that a woman who has had several children will be very apt to think that she is again pregnant. Women do not like to admit the “change of life,” for it is an admission of coming age, and oftentimes, at this period, from unconscious sympathy, unconscious cerebration they will suffer from nausea, and a quivering of the abdominal muscles will be mistaken for fetal “quickening.” There will be many of the symptoms of pregnancy; her abdomen will grow rapidly (from the deposition of fat and accumulation of gases) and, as she was never mistaken before, she will be sure that she is pregnant. Nine months will go by, and when no baby appears, she will think she has a tumor. The old family physician, who has attended the woman in her numerous confinements, will be very apt to be deceived by these cases. Careful examination would elicit resonance at every part of the enlarged abdomen (save in enormously fat women) which would be impossible if pregnancy existed. Let the woman draw up her knees and you grasp the abdominal wall and you can see how much fat you can exclude from the supposed tumor. Some women cannot get the idea out of their heads that they are pregnant. I once had a woman who came to the hospital off and on for four years, insisting that she was pregnant; she declared that she felt the movements of the fetus. On one occasion I told the following story to the class in her presence, and this seemed to do the work, for she never came back: A certain French woman for years made the tour of the Paris physicians, declaring that she was pregnant. Finally she visited Nelaton and told him that she had been pregnant for twenty-one years and that she was sure “it was a boy;” well, said Nelaton, my advice to you is to swallow a tumor.

We have phantom tumors which disappear under ether; how they are produced I do not positively know. Some say they are due to arching of the spine, but I am inclined to think they are caused by a knotty contraction of the abdominal muscles and of the intestines. They will be resonant, however, but the only way to surely detect them is by ether. Sometimes the cessation of menstruation and the appearance of a phantom tumor during the child-bearing period in a woman who desires chil-

dren, will puzzle you very much, but ether will solve the problem. The sound will always settle the question, but it is a dangerous instrument, and you must always be on your guard against designing women who thus endeavor to have a miscarriage brought about.

Remember that when the os uteri is as hard as the tip of your nose, pregnancy is very unlikely, but when it is as soft as your lips it is very probable. If a woman is pregnant, she will pass water frequently at night, owing to the pressure of the uterus on the bladder; so you must consider the collateral symptoms before you resort to the sound.

In bad ante and retro-flexions and in tumors I have occasionally seen the os soft, owing to interference with the circulation. A golden rule is always to fully decide as to pregnancy before you pass the sound. —Goodell. —*Med. Review.*

SHORTENING THE ROUND LIGAMENTS.—Prof. Ashby, of Baltimore, thus concludes an excellent paper on the above subject:

1. The round ligaments are designed to hold the uterus in its axis in the pelvis, and to draw the fundus of the organ towards the symphysis pubis. They have little, if any, sustaining power in preventing procidentia, except in extreme degrees of descent, where the organ has escaped outside the vulva. Posterior displacement of the uterus can only take place when the round ligaments have been relaxed or stretched by prolonged tension.

2. Shortening the round ligaments is a practical method by which the uterus may be lifted into its normal axis and be retained in position by a restoration of its normal supports.

3. This operation is admissible in all cases of posterior displacement where the uterus is not fixed by any adhesions, but perfectly movable in the pelvis, and where other methods of support are not of service.

4. The operation can prove of little value in cases of procidentia, except when employed in conjunction with other methods instituted to overcome this form of displacement.

5. The operation can be easily performed by one who is familiar with the anatomy of the parts. It is almost devoid of danger if ordinary safeguards are employed.

6. In the class of cases to which it is limited, the benefits secured are striking and important.

SURGERY.

DILATATION OF URETHRAL STRICTURES, OF LARGE CALIBRE, IN THE TREATMENT OF GLEET. (F. N. OTIS, M. D.—*Jour. Cut. and Gen. Ur. Dis.*)—Nothing is more distinctly laid down in the writings of authorities in regard to the treatment of urethral stricture than that the results of dilatation are always of a temporary character. It is therefore well understood in the cases of cure of gleet by dilatation of the stricture or strictures upon which it is dependent, that subsequent dilatation must be kept up, *indefinitely*, at varying intervals, in order that the gleet may not be re-established.

For a permanent cure, a complete division of the stricture or strictures must be had, and any treatment which falls short of this will, of necessity, fail in doing more than to temporarily remove the obstruction which has been the cause of the gleet. It is, however, desirable that a temporizing course should be pursued in many cases, for various reasons, just as in many cases it may be found better to pay the interest on a mortgage rather than to pay it off. In some cases, there will be the want of time and means; in some, lack of instruments, skill, and experience necessary to a radical cure of stricture. In a very large proportion of cases, the prejudice against any cutting operation will be the sole objection, and this is encouraged by the advocates of dilatation who refuse to accept the well-authenticated evidence of prompt, satisfactory, and complete cure of stricture and of the gleet through complete divisions, and who persistently ignore the possible perils of its continuance. These also underrate the dangers of dilatation, while exaggerating the risks and discomforts of dilating urethrotomy. For such and perhaps other reasons, the treatment by gradual dilatation will be required in many cases. Directions for its proper performance are therefore appended, as follows:

For dilatation of strictures of large calibre, or those above 20 F., I prefer the solid nickel-plated sound. The essentials of a solid metal instrument, for easy passage through the urethra, are; 1st, that it shall have a highly polished surface, steel or nickel-plated; 2d, that its extremity shall be so curved that, in its passage through the urethra, it shall naturally follow the course of that canal, readily conforming to what is known as the *sub pubic curve*. Urethral sounds, as usually constructed, consist of a straight portion, from six to eight inches in length; the curved portion from two and one-half to three and one-quarter inches in length on its convex surface. The length of this curve between these limits is not of

importance; the one, as a rule, which is the easiest of introduction is that to which you are the most accustomed. Sir H. Thomson and Prof. Van Buren's sounds have a curve of three and one-fourth inches. My own preference is for the shorter curve; this seems to me more easy to direct, enables the operator to be more sure of the 'exact locality of its point than those of the longer arc, and readily adapts itself to the sub-pubic curve.

The sub-pubic curve is found in the well-formed human subject to correspond to the arc of a circle three and one-fourth inches in diameter, the chord of the arc being two inches and three-fourths, and coincides with the course of the urethra from its junction with the bladder to a point an inch and a half anterior to the bulb. The lowest point of the curve is just about opposite the anterior layer of the triangular ligament when the body is upright. In children this curve is more acute, and in old men with enlarged prostate it is more obtuse (Sir H. T.), but in the well-formed adult it is as above stated.

All solid instruments intended for passage through the deep urethra should be formed so as to correspond with the *sub pubic curve*, and this curve should always be borne in mind when attempting to introduce such instruments.

Mode of Introduction.—Taking up the penis carefully, so as to partially include the glans between the first two fingers and thumb, and taking up the sound lightly as you would a penholder, introduce it well-oiled, pretty much by its own weight, turning it slowly if any halting occurs, in this way relieving its point from any obstructive folds of mucous membrane or engagement in a false passage, or natural sulcus. The larger the instrument used the less liable to arrest from such causes. Always begin with the largest instrument which the meatus will permit. In cases of contracted orifice, a division may be necessary before any satisfactory introduction can be effected.

As the sound is advanced, gently draw up the penis on the sound to meet it, keeping the handle of the instrument well down as the abdomen is approached, thus avoiding arrest by the anterior border of the triangular ligament; then advance by slowly depressing the handle until the instrument, following the deep urethral curve, passes well into the bladder. Obstructions may, however, be met. In the anterior or movable portion of the canal,* if there be no stricture, we need have no trouble in passing a large instrument. Small instruments, however, (say of eight or ten m. circ.) may engage in the little follicular sulci which

are not infrequently present at different points, especially in the superior wall of the urethra. Quite a large one is usually met at about one inch from the urethral orifice. This is called the *lacuna magna*. Spasmodic contraction of the anterior urethra is rare, but if the mucous membrane is in an irritable condition, it may arrest, temporarily, the progress of even a full-sized instrument. It is at the bulbo membranous junction, from five to six inches down, that we are most likely to have an instrument arrested. First mechanically, by the anterior border of the triangular ligament. A little tilting upwards of the handle of the instrument will clear this obstruction, and then the point will bear against the anterior aspect of the membranous portion of the urethra. The circular muscular fibres which surround this are continuous with the muscular coat of the bladder, and are abundantly developed here; besides these, the compressor urethræ muscle surrounds the whole length of the membranous urethra. It is here that the spasmodic contractions of the muscular structures surrounding the canal most frequently hinder, to a greater or less degree, the advance of instruments, not seldom completely barring their passage into the bladder. Arrest of an instrument at this point *is the rule*, and undue haste or violence will but increase the difficulty. The simple weight of the instrument, allowed to bear steadily against the face of the closed walls for a few seconds, will usually cause the contraction to yield; when, slowly depressing the handle of sound, it will glide easily into the bladder. The interval between the acts of introducing sound or other instrument for the gradual dilatation of stricture should never be less than two days, and, where irritation is produced by it, this should be allowed to subside entirely before the operation is repeated, using emollient and sedative injections in the mean time. Among the effects distinctly traceable to irritation caused by the introduction of sounds, more particularly through the deep urethra, is a peculiar fever termed *urethral fever*.

In many cases, however, in which I explore the urethra, I do not pass the instrument *into the bladder*, for the reason that stricture is very seldom situated near the bladder. I cannot be too emphatic in warning you to keep out of your patient's bladder. Do not enter it even for exploratory purposes, unless you think it absolutely necessary to do so. First explore the anterior urethra and relieve, as far as practicable any abnormal condition that may exist there. Keep out of the bladder if possible. It is the disposition of the profession all over the world, when exploring a urethra or dilating a stricture, to pass the instrument on into the

bladder. Now, there is absolutely no danger in passing an instrument gently down to the membranous junction, but there is always danger in passing an instrument beyond that point on into the bladder. Death has occurred in more than one instance from suppression of urine through a reflex irritation, caused by gently passing a bougie into the bladder, where disease of the kidneys and bladder was present. I have known many cases of swelled testicle that occurred simply from the passage of a sound through the deep urethra, and at least one case where the loss of a testicle was directly due to introduction of bougies for dilatation of stricture, thus setting up an orchitis which finally ended in an abscess which destroyed that organ.

Urethral Fever.—This consists of a rigor, more or less severe and prolonged, followed by a temperature sometimes up to 105° , and this is succeeded by a sweat, altogether exactly like an attack of malarial fever, and this not infrequently succeeds the passage of an instrument through a urethra, unusually irritable from any cause, the chill coming on from one or two to twenty-four hours after the instrumentation. In persons of malarial habit, it is most frequent, and unless treated vigorously by quinine, may return like an ordinary quotidian.

It is important in connection with the subject of urethral fever to be aware that the same causes which induce it, or the nervous disturbance caused by the attack, may, through reflex irritation, produce a partial or complete *suppression of urine*. This is most likely to occur in cases complicated by organic disease of the kidneys. Harrison, of Liverpool, has called especial attention to the danger of its occurrence in elderly men who habitually pass large quantities of pale urine. Such an accident calls for prompt revulsive treatment by dry-cupping over the loins; turpentine and hot water stupes, and the galvano-faradic current is also claimed to be of service in restoring the excretory functions of the kidneys. In my own experience, a large dose of calomel, twenty to thirty grains, has on several occasions acted promptly in producing this result.

I view of the possibilities of urethral fever and the other troubles which have been alluded to as occasioned by the passage of instruments through the deep urethra, more especially in elderly people, or those in which the urethra is especially sensitive, it is wise to administer quinine, five or ten grains, in such cases, by the mouth or in suppositories, at least an hour or two previous to the attempted introduction of the instrument, for in this way, and with suitable rest (preferably in bed) from

twelve to twenty-four hours afterward, the danger of such troublesome consequences may be reduced to the minimum.

AMPUTATIONS OF JOINT DISEASES IN TUBERCULOUS SUBJECTS.—(Dr. L. S. Pilcher in *Phil Medical News*).

1. The probabilities of a spontaneous cure, or prolonged abeyance of a tubercular bone or joint trouble, as the result of expectant and palliative treatment—*e. g.*, improved hygiene, rest, counter-irritation—is much greater in children than in adults.

2. The probability of the presence or early development of lung tuberculosis in case of tubercular bone and joint affections, is much greater in adults than in children.

3. Incomplete operations, as drainage and irrigation of joints, evidence, and resections in which all of the diseased tissue is not removed, are less likely to be followed by ultimate good results in adults than in children.

4. Operative interference of a radical character is justifiable at an earlier date, in the history of a bone or joint tubercular affection, in an adult than in a child.

5. When a lung tuberculosis is present, and an operation for the relief of a co-existing bone or joint affection is indicated, as the result of such operation the lung affection, while in some cases influenced, is more frequently temporarily checked in its progress, and in some instances is apparently entirely removed.

6. Local relapse after operation for an osteo-arthritic tubercular disease, lung tuberculosis co-existing, is exclusively conditioned upon incompleteness of the operation—the fact that somewhere tubercular tissue escaped removal—and not upon any influence exerted by the lung affection.

7. In any case of osteo-arthritic tuberculosis demanding operation, in which a doubt exist as to the possibility of removing absolutely all the diseased tissue by the more conservative method of arthrectomy or excision, the co-existence of lung tuberculosis would be a circumstance that would add weight to the reasons for having recourse to the more radical operation of amputation.

8. After an amputation in perfectly healthy parts, as prompt healing may be expected in persons suffering from lung tuberculosis, as after such an operation in a healthy person. Relapses at the stump do not occur even in persons with advanced lung disease.

A PAINLESS SUTURE.—Very frequently after the healing of wounds of the face, the most notable features of the scar are the pits and creases caused by the sutures used in approximating and closing the wound. In many—indeed, in the great majority of the cases of incised wounds of the face and other portions of the body, where the treatment is applicable, the ordinary methods of stitching may be replaced by the following, which not only avoids pitting and marking, but has the great advantage of being painless.

Cut two pieces of adhesive plaster somewhat longer than the wound, and from an inch and a quarter to an inch and a half wide. They should be shaped so that one edge of each will follow the course of the lesion, if the latter be straight or simply curved; but if the wound be irregular or “zig-zagged” it is better to use more pieces. Turn the inner edge (or that intended to be next to the wound) of these strips under so as to form a non-adhesive border a quarter of an inch wide, and leave an adhesive surface of from three-quarters of an inch to an inch in width. Apply these to the uninjured skin on each side of the wound, and make them adhere firmly by holding them to this with a hot, dry towel. The stitches may now be taken from side to side, thrusting the needle through the doubled edge of the plaster instead of through the skin, and after the manner of shoe-lacing, uninterrupted. By drawing on the ends of the thread the nicest coaptation of the skin may be obtained. Instead of the ordinary plaster a perforated or porous plaster may be used, the perforations being utilized as eyelets.—*St. Louis Med. and Surg. Journal.*

TO ASCERTAIN WHETHER GANGRENE IS LIKELY TO FOLLOW SEVERE INJURY OF A LIMB.—Gently raise the limb, and keep it raised for two or three minutes, in order to empty it to some extent of blood, then apply a tourniquet, or piece of elastic webbing, on the proximal side of the injury, and keep it applied for about a minute—lower the limb, remove the tourniquet, and if sufficient circulation remains, the part beyond the seat of injury will blush rosy red, and will show in an unmistakable manner the condition of the blood-vessels.

This procedure was adopted by the writer in a case of severe compound comminuted fracture of both bones of the leg. The limb was almost “dangling” and apparently hopeless, but after having adopted the process above described, it was observed that the dorsum of the foot blushed after the elastic webbing had been relaxed.

The boy made an excellent recovery with a useful limb. — *W. S. Lang, M. D., in Edin. Med. Jour.—Analectic.*

A SUGGESTION FOR REDUCING DISLOCATIONS OF THE FINGERS.—By J. W. MACFARLANE, M. D.—While demonstrating to a class on minor surgery the appliances used to reduce dislocation of the fingers, some difficulty was experienced in keeping *Levis's* instrument in position, even with a wet bandage applied to the part.

Having of late been obliged to wear some of the gum finger-stalls of the shops, to avoid poisoning in a cut, and recognizing how they adhered when once in position, the idea suggested itself that one of these would be an excellent covering for the finger, over which *Levis's* instrument or a clove-hitch could be secured if desired.

A close-fitting gum finger-stall was then applied, and, upon grasping with the right hand the finger so covered, we found that we had such a power and perfect control that further appliances were unnecessary,—slipping being out of the question with a finger so covered, especially if the operator's hand is warm.

This simple suggestion may perhaps not have the merit of originality, although I have never come across it before; but it seems to me that much more accurate and judicious traction can be made when the dislocated finger is in the firm grasp of the fingers of the right hand, while the thumb of the right and the whole of the left hand are free to manipulate with, than in the customary method of procedure. Or, if desired, the gum finger-stall can be used as a fixation-point for *Levis's* instrument or the application of a clove-hitch.—*Phil. Med. Times*.

SIMPLE APPARATUS FOR WASHING OUT THE BLADDER.—An eight- or twelve-ounce glass bottle has its bottom cut off, and a cork perforated by two glass tubes is now introduced and sealed, to prevent leakage of air or water. To one glass tube, by five feet of rubber tubing, is attached a rubber catheter. To the evacuating tube is attached one foot of rubber tubing clamped by a bull dog forceps or patent clothes-pin.

The safety of this apparatus lies in the fact that the evacuating tube reaches within the neck of the bottle one half inch beyond the injecting tube, so that, when held upright, there is no possible chance, while emptying the bottle through the former, for air to enter the latter.

Four pieces of cork held at regular intervals by a narrow rubber band prevent the bottle from rolling off the table, while the patient—either standing or seated—introduces the catheter; upon the entrance of which within the bladder the bottle is held and brought below the level of the bladder. The bladder being thus emptied, the forceps is removed

from the evacuating tube and all the urine passes into a vessel except the half thimbleful that remains in the neck of the bottle, to guard against the entrance of air within the injecting tube.

The clamp is now replaced and the fluid to be used for injection is poured into the bottle which is slowly raised to a proper distance above the bladder, which gradually fills; the operator readily observing through the glass that it be not raised so high that the level of the fluid falls below the end of the short glass tube.

Having once introduced the catheter, this process of filling and emptying may be repeated as often as desired, without laying down the bottle, by the careful raising and lowering of which, the distension of, and pressure within, the bladder may be regulated.

In this apparatus we have no syringe, no tap to turn, no injecting nozzle which has to be repeatedly connected and disconnected with the catheter, and no doubt about its safety, for we see what we are doing.

A ready way to remove the bottom of a bottle is to file a groove, with a three-cornered file wet with turpentine, deep enough to hold in place a piece of strong twine. The twine is then drawn to and fro until the glass becomes hot. If now the bottle be immersed in cold water, the bottom separates along the filed groove.—*Dr. Holyoke in Boston Med. and Surg. Jour.*

SWEATING FEET.—The editor of the *Jour. of Cut. and Gen.-Ur. Dis.* says that the best results have been obtained from the use of foot baths of a strong solution of extract of *pinus canadensis* (Kennedy's) every night, and powdered boracic acid, or salicylic acid mixed with lycopodium, oxide of zinc, or other inert powders, constantly used inside the stockings. Hebra's treatment, with diachylon ointment, is undoubtedly efficacious, but the inconvenience attending its application, often temporarily interfering with the occupation of the patient, renders its employment usually undesirable.

ETHER IN BRIGHT'S DISEASE.—The danger of administering ether to persons suffering from Bright's disease is not sufficiently insisted upon, at least in this country. In England the contraindication is more heeded, but as chloroform is still used much oftener than ether in that country, there is less danger of making the mistake. It is the custom with those who use ether for producing anesthesia, to the entire exclusion of chloroform, to administer ether during the convulsions in cases of puerperal eclampsia, whether due to acute nephritis or not; here of all places

chloroform is the better agent to use, both because of its less injurious effect upon the kidneys and because the condition of pregnancy so greatly diminishes its ordinary dangers. Just how ether affects the kidneys is not known. It is freely eliminated by these organs, and it is suggested that its effect is to paralyze the renal nerves, giving rise to congestion which aggravates the existing trouble, while another source of danger may be in the presence in the system of the ether itself, which cannot be eliminated by the diseased kidneys.—*N. W. Lancet.*

THE FLAXSEED FALLACY.—If we were to ask every man and woman in almost any community, what is the best way to get any foreign substance out of the eye, probably fully one-half of those questioned would say, "put a flaxseed into the eye—it's a sure cure!" Every few days some one who has followed this advice comes to me for relief. Only a day or two ago a young man, with an eye full of flaxseed, came to me, stating that the seed had been in the organ all night, and that he could not sleep, because all night long *he could feel the seed chasing the foreign substance around and around under the lid*, but for some strange reason the substance "could not be forced out!" I have never seen any account of the origin of this superstition—for it is nothing more—but it is probably very ancient; but unlike most ancient superstitions of this sort, it has absolutely no basis in fact. Any one who has a foreign substance in the eye and sends a flaxseed to "chase it out," simply adds fuel to the flame. It is fortunate that the seeds are smooth and comparatively unirritating, as otherwise the fallacy would be a more serious one. Another and similar superstition is that foreign matters may be chased out by a "stone from a crab's eye"—which is nothing more nor less than the crystalline lens of the eye of the crustacean, hardened by boiling. In their eagerness to do something in emergencies, the great mass of people rarely use common-sense—if they did they would know that when one is not absolutely certain what to do, the best plan is to do nothing.—A. D. Williams, in *St. Louis Med. and Surg. Jour.*

CRUDE PETROLEUM AS AN ANTISEPTIC DRESSING.—Having been in active practice for about twenty-five years in the woods, where accidents are frequent and the resources for dressings limited, I wish to give the results of my experience in treating gunshot-wounds, resections, compound fractures, injections in abscesses, extensive sloughing, snake-bites, and burns, with petroleum. I use the pure heavy oil from the wells of West Virginia. In exploring a wound I use it on the probe or finger. After

cleaning the wound, I then pour it full and keep it so until it is entirely healed. I will briefly refer to a few cases:

CASE 1. P. M., gunshot-wound of upper thigh: poured wound full, after being tamponed on under side; kept it full of oil until it entirely healed, and without a drop of pus.

CASE 2. Mrs. S., resection of os calcis: kept wound well saturated with oil; it healed without an unkind symptom.

CASE 3. O. D., terribly lacerated hand from gun bursting: kept hand well swathed, using a gallon of the oil, with the very best result.

CASE 4. G. A., legs crushed in saw-mill, compound fracture, with resection: dressed as above; very little suppuration, and perfect repair.

I could cite many similar cases. In a lacerated or sloughing wound, it being heavier than the serum and pus, it penetrates every part of the wound and floats them out. In a slicing wound I use white wool yarn (which is slightly elastic) dipped in the oil, and wind the slice perfectly in place, leave it on a week, and find union with no scar. Since using petroleum I have never had a case of erysipelas or septic poisoning from a wound of any description, and as a local application for inflamed surfaces or herpetic eruptions it is the best I have found. The only objections are the slightly unpleasant odor and staining of the linen. But it is clean, grateful to the patient, and perfectly antiseptic. I would recommend for it a fair trial by the profession.—William P. McKibbin, M. D., in *Phil. Med. Times*.

NINE or ten inches below the tubercle of the tibia is the best place to amputate in order to get the *best stump* for the application of an artificial leg.—Prof. Brinton.

WHENEVER during the course of wound repair the temperature reaches 102° F. on two successive days, a careful examination for the cause of such temperature should be made.—*Practice*.

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MEDICINE.

HEADACHE—INDIAN HEMP.—Dr. Stephen McKenzie (*Brit. Med. Jour.*) recommends very highly Indian hemp in the treatment of a particular form of headache.

The headache is of a dull, continuous, or subcontinuous character, attended sometimes with paroxysmal exacerbations. What is especially characteristic of it is its constancy. Patients rise with it in the morning, are troubled with it all day, and carry it to bed with them at night. If by chance they awake in the night, they find their head is aching. The headache may in some cases become aggravated as the day advances, but sometimes the opposite condition obtains, and the headache is worse at the early part of the day. The situation of the headache varies; it may be frontal, temporal, or occipital, or, more rarely, vertical. Usually, however, it is diffused. It is not as a rule attended with local soreness or tenderness. Nausea may be present, but is not constant; vomiting is usually absent. In some cases, distinct exacerbations, sometimes of great severity, occur. As these subside, they give place to the dull, continuous headache that preceded their advent. As a rule, the ocular phenomena characteristic of migraine are absent, and the headaches are not usually hemicranial. Constipation is present in a certain number of cases, but removal of the constipation does not cure the headache. In some cases it is connected with disorders of digestion, but the same remark applies to these as to constipation. Headaches of this type may last for weeks, months, or even years. They occur in persons of different ages, but are, perhaps, most common in the middle period of life, and in young adults. Patients so suffering are usually able to pursue their usual avocations, except, perhaps, during paroxysmal exacerbation, especially when their work is of an active rather than of a sedentary and intellectual character.

For the relief of headaches of this class, Dr. M. has found Indian hemp of the greatest service. In the majority of cases, it cures the complaint. The one element of the headache which, in his experience, indicates the probable success of the remedy, is its continuous character.

The preparation of Indian hemp he always employs is the extract. He begins by giving one third or more (usually half a grain) night and morning, or occasionally three times a day. If at the end of a week some amelioration of the headaches has been procured, he advises its continued use in the same doses; but if little or no improvement has

taken place, he increases the dose to one grain at night and half a grain in the morning. If this is insufficient, he increases the dose so as to make it one grain night and morning; this failing, he increases it by half grain doses, giving the maximum dose at night, until two grains at night and one and a half grains in the morning are reached. He has scarcely ever had occasion to exceed these doses. There are two points he urges :

1. The gradually increasing dose.
2. Steady perseverance in its employment. The treatment must be as obstinate as the disease.

Given in these doses, usually no inconvenience is experienced by those taking cannabis indica; but a few patients have complained of a feeling of slight confusion or giddiness, not in any way so annoying as the confusion for which it was administered.

The length of time over which treatment has to be continued varies in different cases; usually, it extends over several weeks, but rebellious cases may require a treatment of two or three months. As the malady recedes, the dose should be reduced, and it is advisable to continue the administration of the remedy for a week or two after the headache has disappeared.

SUDDEN AND TOTAL DEAFNESS A SYMPTOM OF CEREBRO-SPINAL MENINGITIS.—I recently examined a child, two years old, which a year ago fell ill, and became suddenly totally deaf, and has remained so ever since. Examination disclosed no visible cause for the condition. Both drums were in a normal condition and had evidently never been seriously injured or diseased. The conclusion therefore was that the cause of deafness was cerebral—without doubt the result of spotted fever. And though the physician who attended the infant during the attack did not suspect cerebro-spinal meningitis, I learned, on close inquiry, that in the earlier part of its illness the body was bent, so that the child rested on the back of its head and its heels, and the mother said it required considerable force to straighten it. My experience has shown that whenever a person, young or old, during an illness becomes suddenly deaf, the attack is one of cerebro-spinal meningitis. There is no other disease which suddenly so gravely affects the audition. This it does by destroying the labyrinths (whenever it attacks them at all). Persons affected with some other grave diseases, may suddenly become hard of hearing or partially deaf, but rarely or never entirely so.—Dr. A. D. Williams, in *St. Louis Med. and Surg. Jour.*

CEREBRAL LOCALIZATION.—For its convenience for reference, we reproduce the following conclusions, from an article by Dr. Henry Hun, in the *Amer. Jour. Med. Sciences*:

1. The greater part of the cerebral cortex can be divided into small areas, each of which is functionally associated with a definite mode of mental action, and is consequently called the cortical center for that action.

2. The cortical centers connected with the sensory nerves are situated in the posterior half of the cerebral cortex, including the temporal lobe, and the cortical centers connected with the motor nerves are situated in the middle portion of the cerebral cortex and in the posterior part of the cortex of the anterior lobe.

3. Each sensory cortical center probably consists of two parts; a smaller one in which the peripheral one has its termination, and in which take place those molecular changes which correspond to simple sensation; and a larger one in which take place those changes which correspond to mental processes of memory, judgment and comparison, which together constitute complete perception and recognition.

4. Each motor cortical center probably consists of two parts; a smaller one in which the peripheral motor nerve has its origin, and in which take place those molecular changes which correspond to the action of the will to originating voluntary movements; and a larger part in which take place those molecular changes which correspond to the memories of coordinated muscular innervation which are factors in the production of voluntary movements.

5. The optic nerve fibres from the right upper quadrant of each retina terminate in the lower half of the right cuneus.

6. The optic fibres from the right lower quadrant of each retina terminate in the adjacent part of the right median occipito-temporal convolutions.

7. The lower half of the cuneus and the adjacent part of the median occipito-temporal convolution is the point of termination of the optic nerve fibres from homonymous halves of the retinae; the right half of each retina being represented in the right occipital lobe and left half in the left lobe.

8. Functional activity of the cortex of the median surface of the occipital lobe is necessary for simple visual sensation.

9. Functional activity of the cortex of the convex surface of the

left occipital lobe is necessary for full visual perception and recognition and for the production of visual memories.

10. The temporal lobe is the cortical center for hearing, and complete destruction of a temporal lobe or of the auditory fibres running to it causes complete deafness of the opposite ear.

11. Functional activity of the cortex of the left superior temporal convolution is necessary for the perception and recognition of spoken words and for the production of the memory of these words; lesions of this part causing inability to understand spoken words and sensory aphasia.

12. Functional activity of the cortex of the left angular convolution is necessary for the production of memories of the appearance of written or printed words, lesions of it causing alexia and agraphia.

13. Only in virtue of the fact that on its functional activity depends the production of the memory of the appearance of written or printed words can the angular convolution be considered as forming part of the visual centre. It does not constitute the visual center.

14. The cortical center for the leg includes the paracental lobule, the upper third of the two central convolutions, and the greater part of superior parietal lobule.

15. The cortical center for the arm includes the posterior part of the superior frontal convolution, the middle third of the two central convolutions, and the anterior part of the inferior parietal lobule.

16. The cortical center for the face includes the lower third of the two central convolutions, especially the anterior one.

17. In the anterior part of the cortical center for the arm originate the nerve fibres for the arm, and lesions of this part cause absolute paralysis of the arm. The same thing is probably true in the cortical center of the leg and arm.

18. In the posterior part of the cortical center for the arm take place those molecular changes which are necessary for the production of memories of coordinated muscular innervation. The same thing is probably true of the cortical centers for the leg and face.

19. No sharp line can be drawn between the motor centers of the leg, arm and face, and it is very possible that in each center all three parts may be more or less completely represented.

20. The cortical centers for muscular and cutaneous sensibility are the same as those for motility, and probably extend backward beyond the latter over the parietal lobe.

21. The faculty of speech cannot be located in any one portion of the cortex, and aphasia can be produced by a lesion situated in various parts of the left cerebral hemisphere; the right hemisphere not being concerned in the production of speech except in the case of left-handed persons.

22. Tumors or other irritative lesions situated in the non-motor region of the cerebral hemispheres can cause general convulsions associated with loss of consciousness.

23. Tumors or other irritative lesions situated in the cortical centers for the arm or leg or face may cause convulsions commencing in the leg, arm or face respectively and which may become general, though they more frequently remain unilateral, and which are sometimes associated with loss of consciousness and sometimes not.

24. Tumors situated in the cortical center for the leg may produce a trance-like condition, or conditions resembling attacks of petit mal of epileptics.

PATHOLOGY AND TREATMENT OF CHRONIC CONSTIPATION IN CHILDHOOD.—In children the question of constipation is in certain aspects very serious, for it affects not only present health and comfort, but future development and working condition of the alimentary canal for the whole of after-life. There is this difference, further, between the two cases: Indjudicious treatment may render constipation confirmed in the case of the adult. In the case of the child it may do this also, but it may do far more. It may, and often does, cause such serious injury to the bowel itself that it recovers only after long and careful management, even if the damage inflicted be not permanent and incurable. As a general proposition, it may be said, perhaps, that adults suffer most from the consequence of neglect of constipation, children from the too vigorous and mischievous treatment of it. The treatment of constipation in childhood, then, is a subject of considerable importance. To be successful it must comprise something more scientific and comprehensive than the mere administration of aperients. It is not enough to open the canal when blocked, or sweep it clear of accumulations which have lodged there. The essential point is to establish such a habit of daily evacuation that accumulation of the noxious waste and its evil consequences may not recur—to modify the condition permanently. In order to do this the cause which gives rise to it must be thoroughly understood—must be removed, or neutralized, or compensated.

There are many different factors concerned in the production of constipation, which act in varying degree in different cases. 1. Deficient fluid in the intestinal canal, caused by deficient supply in food, excessive waste, or deficient secretion from the intestinal mucous membrane. 2. Deficient peristalsis, especially of the large intestine, from defects of diet, or from atony due to over-stimulation by purgatives or to degeneration of the muscular coat. 3. Inhibitory influences of the nerve centres of the brain and cord, probably affecting both peristalsis and secretion of fluid. 4. Deficient bodily exercise and movement. 5. Dilatation of the intestine, especially the colon, due to debility of the intestinal wall or to actual dilatation by accumulated feces, gaseous distention, repeated enemata, or laxness of the abdominal wall.

Such are the chief causes which give rise to constipation. They are not all met with in the case of children, however—at least not in equal degree. Thus, weakening of the muscular fibre of the intestine by the deterioration of age, mental depression, deficient bodily exercise, or astringent food rarely can be credited with the production of deficient peristalsis in early life. Putting aside malformation, such as atresia more or less complete, peritonitis, intussusception, and the like, the causes which are chiefly operative in childhood are: 1. Food which leaves little residue: very completely digestible food—*e.g.*, milk: fecal matter too small to duly excite peristalsis. This is a common cause in very young children, and in like manner a too great uniformity of food fails to excite peristalsis. 2. Deficiency of liquid in food, not enough to drink, is another not infrequent cause in children: causing too dry feces. 3. Deficient biliary secretion, “*acholia*”: unstimulating feces. 4. Deficient secretion of glands of mucous tract: dry feces. 5. Over-stimulation and consequent atony of intestines: loss of excitability and loss of power, caused—(a) by coarse foods, (b) by frequent purgatives, (c) by too frequent use of enemata. To these may be added the dread of evacuation from pain caused by hard stools. The latter is frequently operative in children. Instead of aiding the evacuation of the bowels, the child resists it with all its might. This resistance to the passage of feces, partly voluntary and partly reflex, is caused by the pain of extrusion through the sphincter of a hard rough mass, or the existence of a fissure or sore of the anus. When once constipation has occurred this is an important cause of its continuance, to be overcome only by inducing absolute liquidity of stools for a time.

Now the symptoms produced by retention of fecal waste in the in-

testine vary remarkably. In some cases, especially in very young milk-fed children (and the fresher and better the cow's milk the more constipating is it, *i. e.*, non-fermenting, not acid), there may be absolutely no derangement of general health. The child eats well, sleeps, is hearty and robust—the picture of health. There appears to be no fecal poisoning by reabsorption of foul matter from the intestine. The chief difficulty is the pain caused by the passage of the hardened dry feces. This causes the child to resist all attempts to go to stool. It screams and cries, and dreads the action, and thus, refusing to assist by its own efforts, the bowels remain closed for days, perhaps, until a good dose of castor oil or other domestic medicine compels evacuation. In addition to this there may be restlessness and night terrors; but the tongue is usually clean, and digestion and nutrition good.

Strong purgations enervate and wear out the tone of the bowel. Continued enemata impair tone and do harm by dilatation. Intermittent treatment aggravates the evil. First, be sure that there is no malformation, intussusception, no painful sore about the anus. Use saline laxatives, as they increase the flow of intestinal fluids. Further aids are strychnia or nux vomica, iron and belladonna.

In the case of children under two, simple carbonate of magnesia (gr. v. to xx.) in milk is sufficient. In older children the sulphates of magnesia and soda, with the above-mentioned tonics and daily massage (abdominal?), are useful. In older children still a pill of aloes or euonymin, with sulphate of iron and nux vomica, may be given as an alternative to the course of salts and strychnia. In mild cases, perhaps, or if the liver is not acting, a dose of calomel, grey powder, and soda and senna may be given. Regimen is an important element in the treatment if the child should have chronic constipation: abundant water, pure, not hard; "salutaris" water is excellent. In little children add a good infants' food to milk; fruits; fruit jellies; treacle; cooked green vegetables of the softer and more delicate kinds. Some variety of food is useful; a good mixture is better than a monotonous diet. It is, I think, extremely doubtful if coarse food is useful in the long run. It causes atony and weariness of muscle eventually by over stimulation. And you must insist on regular evacuations. Take care that the stools are not dry and hard, or the child will resist action and increase constipation. Other useful adjuncts are: abundance of fresh air, which aids in improving nutrition; and exercise, which mechanically aids the passage of the contents of the intestine down the tube, and improves general health and muscular tone.—W. B. Cheadle, in *Lancet—Analectic*.

CASES OF SKIN ERUPTIONS AND SYPHILIS TREATED WITH HORSFORD'S ACID PHOSPHATE.—(Mr. James Startin, Late Honorary Surgeon and Lecturer, St. John's Hospital for Skin Diseases, London ; Honorary Consulting Surgeon to the Sheffield Public Hospital for Skin Diseases).—It appears to me that the "Acid Phosphate" originally prescribed by Prof. Horsford, of Cambridge, U. S. A., is not so well known in this country as its merits deserve. A glance at its formula will however readily convince one of its value in suitable cases. Each fluid drachm gives on analysis $2\frac{1}{2}$ grains of free phosphoric acid, and nearly four grains of phosphate of lime, magnesia, iron and potash. The following are a few brief notes of the cases in which I have prescribed it with complete success :

Mr. G., aged 69, consulted me November, 1885, for eczema on the arms, legs, palms of the hands, and trunk. The patient complained of much debility and nervous exhaustion, and he was a man who had led a very busy business life, with much worry. In December, 1885, I prescribed Horsford's acid tonic with much good effect, as in February, 1886, I heard that he was quite well.

Mrs. S., aged 46, consulted me in December, 1885, for psoriasis all over the body, more or less, especially on the legs and arms. In January, 1886, I prescribed a teaspoonful of the acid tonic three times a day with marked good effect. Patient had been much exhausted by continuous nursing on an invalid mother.

Mr. C., aged 64, consulted me in September, 1885, with one of the worst attacks of late syphilis I ever saw. After he had been relieved from the distressing symptoms, and ulcerations, I prescribed the acid tonic for epileptiform fits from which he suffered, with excellent results.

Mr. McJ., aged 63, consulted me in November, 1885, for lichen ruber, which was accompanied with intolerable itching. He was a nervous, irritable man. I prescribed the acid tonic with the effect that in December he presented himself quite convalescent.—*Med. Press, London, England.*

SORE NIPPLES.—Among the numerous remedies recommended for *sore nipples*, Prof. Parvin pronounces the compound tincture of benzoin the best, as a local application. As the saliva of the infant is liable to be productive of fissures, etc., by its irritation, the nipple should always be carefully cleansed and dried after the nursing of the child.

REMARKS ON THE USES OF PAPINE.—(William J. Crittenden, M.D., Unionville, Va.)—In the practice of medicine we are often called upon to treat patients who possess a peculiar idiosyncrasy as to the effects of opium or any of its preparations.

During January, 1886, I was called to see a lady suffering with acute peritonitis. She assured me that she could not use opium, as she had tired of it previously. But I gave her one-eighth grain of morphia sulphate and one one-hundred-and-twentieth grain of atropia sulphate hypodermically, and in a few moments the depressing effect was noted, both upon the respiration and circulation; the pupils also became visibly contracted. I then tried the various usual substitutes for morphia in succession, but to no effect. I determined to try papine; but not being able to give it by the mouth on account of nausea, and as she objected to the use of the hypodermic needle, I gave her two drachms per rectum, and repeated it in one hour. The result was that she sank into a quiet, peaceful sleep, which lasted for several hours. During the remainder of her sickness I gave her papine with the most gratifying results. As soon as her stomach would retain it, I gave it to her by the mouth in one-drachm doses.

I have also used papine in a case of uterine cancer, in lieu of morphia. In cases in which patients have been taking morphia until it has lost its anodyne influence, papine is well adapted.

Some time ago (in absence of the family physician) I was called to see a lady one night, in great haste, who was suffering with malignant disease of the uterus. On my arrival the nurse informed me that she had given her a grain of morphia, with suitable percentage of atropia, every hour for five or six hours, and during the intervals she had given her chloroform, but to no effect whatever. Accordingly, I gave her xxx min of papine with eighth grain morphia sulphate, repeating it in fifteen minutes, and in a short time she fell asleep and slept for six hours, which was more than she had slept at a time for months.

In pneumonitis, pleuritis and bronchitis, I have found papine to answer an excellent purpose. In dysentery it is useful both as an anodyne and in relieving the tenesmus. In the diarrhea of children I frequently combine with it bismuth sub-nitrate and prepared chalk. I have used it also in cystitis. In neuralgia, when I wish an anodyne, I use papine. As an anodyne it is equal if not superior to morphia; and I have never yet seen any unpleasant effects from its use. As a hypnotic I find it to be an agent of great value.

It is inferior to bromidia when we simply wish the effect of a hypnotic. But it fulfills the indications when we wish a decided anodyne as well as a hypnotic influence.

I trust that the readers of the *Monthly* may give this drug a trial, as I feel that they will be amply repaid for their trouble.—*Va. Med. Monthly*.

AN ANALYSIS OF TWO HUNDRED AND FIFTY AUTOPSIES ON DRUNKARDS.—(Illustrating the most prominent anatomical lesions of chronic alcoholism.)—Dr. Formad, in a paper on the above subject, considered the most conspicuous lesions to be cyanotic induration of the kidneys, fatty infiltration of the liver, and mammillated stomach. His cases had been those in which there had been a history of a long-continued series of debauches, the subject often dying in one of these debauches, and did not include moderate drinkers or those who perished after imbibition of an enormous quantity of alcohol without any previous chronic excesses. He thought that the exposure, irregularities of diet, etc., incident to a state of drunkenness, had much—probably more than the alcohol itself—to do with the productions of the lesions; but it was not at all possible to separate one from the other. He gave a long list of lesions considered by various authors to be results of chronic alcoholism, among which the cirrhotic liver with contraction held a prominent place. He had himself at one time considered cirrhosis a very frequent, if not almost necessary, concomitant of long-continued, excessive use of alcohol, and had even testified in court that a certain person was not likely to have been a hard drinker, because at the autopsy no cirrhosis of the liver was found. He had thought, too, that the connection between the two was so close that it was impossible to have a case of cirrhosis without a previous history of alcoholism, as is held by various authors. Therefore, it was surprising to meet in his two hundred and fifty autopsies with only six cases of cirrhosis of the liver with contraction. In two hundred and twenty cases, the liver was considerably or even very much enlarged, the enlargement in most cases proving to be due to a fatty infiltration. Cyanotic induration of the kidney and chronic gastritis, with mammillation of the stomach, were found in nearly every case. This cyanotic induration is peculiar, and differs from the cyanotic induration due to heart disease.—*Phil. Med. Times*.

COLUMBUS MEDICAL JOURNAL.

EDITORIAL.

HEALTH vs. HEATING AND VENTILATION.

The heating and ventilation of our houses has so much to do with the health and comfort of the inmates that it surprises us that it receives so little attention. With the proper appliances used, the vitiated or foul air is removed, and a supply of fresh admitted, but when such precaution is ignored, the germs of disease gain an easy foothold, and scarlet fever, diphtheria, and other kindred maladies assume a malignant type. Parties building would do well to dispense if necessary with some extravagant ornamentation, and supply their homes with a good hot-water heating apparatus, such as that brought out by Mr. Samuel D. Tompkins, engineer, and manufactured by the A. A. Griffing Iron Co., 518 Communipaw ave., Jersey City, N. J., which meets all the conditions required; *i. e.*, cheapness, durability and effectiveness; the latter, however, being the most prominent. On application the A. A. Griffing Iron Co. will send their handsome illustrated circulars, both of hot water heating and ventilating apparatus, and their numerous constructions for steam uses, and those who may be building, or about to build, would do well to consult the above firm before purchasing heating appliances.

Fluid Forms of Hydrastis.

The reputation of this drug as a therapeutic agent was first gained through its employment in the form of an *infusion*; and in the fifty years following its introduction into medical practice, a continuous effort has been made by manufacturers to perfect a preparation which would represent all the active principles of the drug, without the high price of the salts, either alone or in combination.

The most prejudiced writers on *Materia Medica*, accord to the late Wm. S. Merrell the largest share of credit in the introduction of Hydrastis preparations, and to the present organization the reputation of being the *largest consumers of the drug in the world*. For more than a half-century, Hydrastis has been made a study in our laboratory, and we do not think we exaggerate its importance when we assert that it stands pre-eminent to-day as the most valuable exponent of our vegetable *Materia Medica*.

The following preparations *in fluid form* are receiving our special attention at this time:

Fluid Hydrastis—MERRELL.

Is what its name implies—the active, medicinal principles of the drug in natural combination and in a fluid form. It has a bright, yellow color, perfectly clear, free from sediment, and with an unmistakable odor of the *fresh drug*.

Fluid Hydrastis is a pure, neutral solution of all the alkaloidal constituents of the drug, rejecting the oil, gums, irritating and offensive resins and inert extractive matters. The success attending its introduction is the best evidence of its therapeutic value.

Unsuccessful imitations and would-be substitutes are met with on every hand. Preparations said to be “just as good” or “about the same thing,” but always “a little cheaper,” attest the wide-spread and growing popularity of Fluid Hydrastis. All such, compared with the latter as to physical appearance or as representatives of the drug, *are condemned*; dispensed in prescriptions, *they are readily detected*; tested therapeutically, *they are promptly rejected* as unworthy of confidence.

Fluid Hydrastis is applicable to the treatment of all irritable, inflammatory and ulcerative conditions of the mucous tract.

This statement of a well-known medical writer and journalist has become axiomatic:

“No remedy for physician's use has been received with such universal approval.”

Solution Bismuth and Hydrastia—MERRELL.

An invaluable and scientific combination, wherein the beneficial action of the white alkaloid is increased by association with Bismuth. This solution contains $2\frac{1}{2}$ grains of the double Citrate Bismuth and Hydrastia; twenty-five per cent. of which is Hydrastia Citrate.

The cordial reception accorded this preparation marks it as the most valuable combination in the market in which the white alkaloid alone represents the valuable properties of the drug. Used in diseases of the nasal passages, of the eye, of the throat, of the stomach and intestines, of the reproductive organs and bladder it is equally beneficial.

Colorless Solution of Hydrastia—MERRELL.

This is a permanent solution of the white alkaloid, without the addition of any other medicinal agent to modify or increase its action. It is offered without special recommendation to meet the views of an unlimited number of physicians, with whom the color of the Fluid Hydrastis is an objection. This solution contains in one fluid pint the same proportionate strength of white alkaloid as exists in an average quality of crude root.

See notes above on Solution Bismuth and Hydrastia.

“Merrell's Hydrastis Preparations” are for sale by Wholesale Druggists throughout the United States. Please Specify “Wm. S. M. Chem. Co.” in ordering or prescribing.

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THE STATE SANITARY ASSOCIATION had its most successful meeting on the dates announced in our last issue.

The programme was very full, but there were enough failures to reduce it to good working dimensions. The members of the State Board of Health were nearly all present, showing the cordial relations that exist between the two bodies.

The place of meeting was unfortunately too retired and difficult of access, though the committee did the best it could. Columbus has no small halls adapted to such gatherings, though it is anticipated that the new Board of Trade building, now in contemplation, will supply this demand.

The proceedings will appear, as heretofore, in *The Sanitarian*, of New York. The next meeting will be in Toledo, next February.

THE FIRST SANITARY CONVENTION in Ohio, under the auspices of the State Board, will be held at Warren, Trumbull Co., March 30 and 31. The Board acts in conjunction with a local committee of citizens. An excellent program has been prepared.

We understand that the Board intends to hold about four of these conventions a year, in different parts of the State, so as to familiarize the people with sanitary facts and methods. These gatherings, as held in other States, have done great good, both directly and indirectly.

A DIPLOMA MILL IN MAINE.—The *Boston Herald*, of February 11th, contains an account of the manner in which one of its reporters obtained the degrees of M. D. and A. M., from the "Druidic University

of America, State of Maine Branch." The "University" was situated in the city of Lewiston, Me., and occupied a two and a half story wooden building, ornamented with the sign of "Dr. Samuel York, Druidic Physician." The reporter represented himself as a young man who wished to settle in the city of Mexico to practice medicine. With many assurances that the college did not sell its diplomas, the proprietor exchanged a matriculation ticket and a most elaborate diploma for a small amount of money, which was said to cover cost of printing and other expenses. The aspirant was also put through some very farcical examinations, and given some equally absurd instruction, the whole transaction covering some six hours' time. The Maine Legislature has already taken the necessary steps to repeal the charter of the University.

This same York was recently in Ohio, advertising himself as a "Specialist" who had "resigned his position as dean of the medical department of an Eastern University," in order to take charge of a so-called "Institute" in this city, now managed by a man whose name appears as "Prof. of Surgery" in this "University."

IS IT ANOTHER DIPLOMA MILL?—A rumor having reached this office that a medical college was quietly pursuing the even tenor of its way in the little village of Lebanon, this State, we at once sent a letter of inquiry to one of the most prominent physicians in that region—Warren county. He replied as follows :

"As to a medical college at Lebanon, will say that it is dubbed the 'Med. Dept. of the National Normal University' (Holbrook's). Mr. H., Prest, of the alleged University, drummed around over the county a year or two ago for 'Professors'—M. D.'s who would of course lecture for the honor and bring as large a contribution as possible in the way of a museum. They were promised the influence of the Holbrooks and faculty generally, and students' patronage so far as they could influence it. Three or four young doctors accepted professorships. The faculty, I believe it is said, has always outnumbered the class.

I believe Prof. Holbrook's idea is to turn out M. D.'s by a quicker and better method than the regular, and, as he claims, old-fogy institutions."

We will try to get further information.

This makes *sixteen* institutions in this State which confer the degree of M. D. New York State has twelve such, and Pennsylvania has only six.

REVIEWS AND BOOK NOTICES.

A Reference Handbook of the Medical Sciences, Embracing the Entire Range of Scientific and Practical Medicine and Allied Science. By various writers. Illustrated by chromo-lithographs and fine wood engravings. Edited by Albert H. Buck, M. D., New York City. Volume IV. Bound in cloth, sheep, and half morocco, prices, \$6.00, \$7.00, and \$8.00 per vol. New York: William Wood & Company.

The fourth volume of this magnificent hand book has just been issued. It comprises all subjects between ichthyol and migraine. Of the longer and more important articles we notice that on Inflammation by Dr. W. T. Councilman; Insanity by Drs. Kellogg, Stedman, Brush, Goldsmith, N. S. Davis, Abbott and Etheridge, who severally treat of the different phases and causes. The Kidney, with its diseases, occupies 44 pages, well illustrated. Dr. Ransohoff, of Cincinnati, contributes the portion pertaining to the Surgery of the Kidney. Labor takes up 45 pages. The Larynx, its anatomy, surgery, diseases and foreign growths, occupies 68 pages, and is elegantly illustrated. The articles on Massage and Microscopy are also very complete. The work is the most complete of its kind that has ever been printed in the English language, and supplies what would require a large library to furnish in any other form.

Diseases of the Lungs and Pleuræ, including Consumption. By R. Douglas Powell, M. D., Lond., Fellow of the Royal College of Physicians; Physician to the Middlesex Hospital and to the Hospital for Consumption and Diseases of the Chest, at Brompton; late Assistant Physician and Lecturer on Materia Medica at the Charing Cross Hospital. Third edition, rewritten and enlarged, with illustrations, including two lithographic plates; being Vol. XI. of Wood's Library for 1886 (12 vols. in set, price, \$15 00.) New York, William Wood & Company.

This is an excellent presentation of our present knowledge in regard to these prevalent diseases.

The author does not, from his own experiences, believe that consumption is contagious, although he is not prepared to say that it may not at times become so under favorable circumstances. His short chapter on the Surgical Treatment of Palmonary Cavities is very interesting, as are also those devoted to the consideration of the complications of phthisis.

A Text Book of Medicine for Students and Practitioners. By Dr. Adolph Strumpell, formerly Professor and Director of the Medical Polyclinic at the University at Leipsic. Translated by permission from the second and third German editions by Herman F. Vickery, A. B., M. D., and Philip Coombs Knapp, A. M., M. D., with editorial notes by Frederick C. Shattuck, A. M., M. D., Visiting Physician to the Massachusetts General Hospital, and to the House of the Good Samaritan; Instructor in the Theory and Practice of Physic, Harvard Medical School, etc., Boston, Mass.; with one hundred and eleven illustrations. D. Appleton & Co., 1, 3 and 5 Bond St., New York, 1887.

This book is destined to be a sharp rival of those which now serve as text-books in practice in our medical schools. Harvard has adopted it, and also Starling, of Columbus, and others will very certainly follow. It is a thoroughly good book all through, but what will add more than anything or all else to its popularity is its section on diseases of the nervous system. The treatment of this subject is masterly, and serves to render clear and simple what is ordinarily very perplexing to the student, and even to the practitioner.

Much space is saved by the relegation of pathology to the special treatises on that subject. The translators have done their work well. They have given us "good English," even at the sacrifice of the German idioms. The editor's notes are well-timed and valuable.

A Clinical Manual of the Diseases of the Ear. By Laurence Turnbull, M. D., Ph. G., Aural Surgeon to the Jefferson Medical College Hospital, late Honorary President of the Otological Subsection of the British Medical Association at Cork, and Author of a work on Hygiene of the Ear, etc., etc. With a Colored Lithographic Plate and numerous Illustrations on Wood. Second revised edition. Philadelphia: J. B. Lippincott Company. 1887. Cloth, 8 vo. Pp. 567, Price, \$3.00.

The second edition of this excellent treatise is improved and enlarged, and more fully illustrated. The author's experience in his specialty has been enlarged by the 16 years which have intervened since the issue of the first edition, and especially by his connection with the Jefferson Hospital, where during the last six years he has treated over 10,000 cases of ear disease. With this large accumulation of data to draw from, he gives the profession a most trustworthy book for study and reference. Illustrations are introduced as called for to simplify the text.

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COMMUNICATIONS.

DELIVERY OF THE PLACENTA.

BY H. C. FRAKER, M. D., COLUMBUS, O.

(Read before the Central Ohio Medical Society.)

Man seems to be born with an instinctive desire to get hold of something, and pull. This instinct manifests itself in the directions given, in all the older works on midwifery at my disposal, for the management of the placenta and secundines; consequently the umbilical cord, and quite likely the parturient woman, suffered.

In 1783, Hamilton, of Edinburg, divided the delivery of the placenta into two different classes: natural and tedious; and recommended in the natural division the twisting of the cord two or three times around the fingers of the left hand, to secure a firm hold, and the passing of two fingers of the right hand into the vagina, to give direction to the force, then *pull*; if not successful at the first attempt, wait five minutes, and then repeat the procedure; also apply warm moist cloths to the vulva. In the second division, "tedious delivery," while giving various causes for this tediousness he recommends the same treatment in all; namely, the introduction of the hand within the uterus and the grasping of the placental mass, thus stimulating the uterus to contraction. In hour-glass contraction he recommends the exhibition of large doses of opium, giving

from forty to sixty drops of L. L. Just what "L. L." means I do not know.

About 1818 to '20, Dewees published his work on midwifery, and in this recommends rubbing the belly of the woman, first, last and all the time, for any and all causes, obstructions, or difficulties to which parturient woman may be exposed.

In 1828, Dr. Samuel Jackson wrote and published an elaborate monograph on this subject. He divides the management into two classes: namely, that attended by natural hemorrhage and that attended by an unnatural, or excessive, hemorrhage. In the first class, he advises letting the cord severely alone, the passing of one or two fingers into the vagina and hooking them into the lower or presenting edge of the afterbirth, at the same time performing Dewees's rubbing act. In the second class, after giving the various causes for unusual hemorrhage: namely, uterine inertia, irregular contractions of various degrees, lacerations, etc., he advises rubbing, pressing in various directions, and the introduction of the hand for the purpose of stimulating normal contractions, and removal of the afterbirth; but he especially cautions against the use of ergot in irregular contractions, as increasing the abnormal contraction and rendering the subsequent delivery more difficult.

In Cazeaux's earlier editions, published during the forties, the old stereotyped plan of pulling on the cord is recommended, delivery of the secundines being divided into natural and artificial. In the artificial the hand and the use of ergot are mainly relied upon, and in the order given. Strange as it may now seem, one of the causes of artificial delivery given is weakness, or fragility, of the cord.

Bedford, in his 4th edition, published in '68, still adheres to the cord, but with this caution, to be sure that the placenta has been loosened and is ready to be expelled before pulling. This caution is an indication of discontent and uneasiness with the old method, and a desire to improve upon the methods handed down through generation after generation of physicians, from the fathers of medicine and the obstetrical art. Within the next few years Crede startled the obstetrical world by the publication of the method now bearing his name, this, with the statistics given by him and others following in his footsteps, has almost revolutionized the method of procedure in the third stage of labor. Almost every physician at present practices this method in a complete, or more or less incomplete manner. The term expression, or pressing out, defines this method exactly; it is the grasping of the uterus in its entirety, and exert-

ing equable pressure upon all sides, rather than the *massage* of Jackson and others.

Within two or three years past, antiseptics and asepsis have received their full share of attention from obstetrical practitioners; they have been applied to labor in its entirety, at various hospitals, and after various methods, each practitioner having his own method, and relying upon reports, with very favorable results. The benefits of antiseptics seem to me to be more in the general attention to the minutiae of practice and carefulness to secure cleanliness, than in the sprays, acids, etc., used.

From the above review you will notice that to make a concise classification, of this third stage of labor, is almost an impossibility; each author forms his own classification and leaves this open to objection. The natural and tedious would depend upon the practitioner's patience. The natural and unnatural hemorrhage, upon the appreciation of the amount of blood lost and judgment as to what constituted an unnatural amount, while delivery may be delayed by causes which may almost entirely prevent the loss of blood. The classification natural and artificial, is better, but is still open to the objection that it does not define the line of demarcation definitely, but leaves it to the judgment of the practitioner.

For practical purposes it seems to me that classification is useless and confusing; that a simple statement of the causes which may lead to obstruction, or deviation from the normal, or physiological process, with the descriptions of the methods in vogue for overcoming these obstructions, would be preferable.

In the management of natural cases, the less management or treatment the better. The afterbirth may be removed, from the vagina, by almost any method, the main point being to be sure it is loosened, and either expelled from the womb or lying in the mouth of this organ, before applying this method. My own practice is to introduce one or two fingers, hook them into the presenting edge of the afterbirth and so remove it. With a certain class of multiparæ, possessing very relaxed abdominal walls, Crede's method possesses decided advantages, the thorough emptying of the uterus markedly preventing distressing after-pain. In obstructions or deviations, the method must vary with the cause. These obstructions or deviations are: first, adhesions of various degrees of the placenta to the uterine wall; second, uterine inertia, or exhaustion; third, irregular contractions. Adhesions may be recognized by the irregular, or flattened, shape of the uterus, and are treated by rub-

bing the fundus of the uterus, massage, Crede's method, and the introduction of the hand and forcible separation, in the order named. Inertia, by stimulating contraction by cotton root, cinnamon, and whiskey; after moderate contractions are established, Crede's method. Irregular contractions, by overcoming the irregularity with chloroform and the hand. The irregular contraction will usually be found at the mouth of the womb, and is usually the result of early administrations of ergot. Hemorrhage may occur in all of these varieties, and the amount will determine the vigor with which the above named means must be employed.

Now a word with regard to the use of ergot; from my experience with it, I have relegated it to use after the expulsion of the afterbirth, for the following reasons: first, in normal cases we do not need it; second, in abnormal cases it almost invariably causes spasm of the mouth of the womb, and renders more difficult any operation that may become necessary.

In writing this review I have not endeavored to quote all authors, but only representative ones, at nearly regular periods of time, in the period covered, and to give the general treatment at each time, and my article is intended to be more suggestive than explicit.

A LIBERAL RULING.—In the now somewhat noted malpractice case of *Winters vs. Graves*, recently decided in California, the court in the instructions to the jury used the following language:

"A physician of ordinary skill, exercising ordinary skill and care in his diagnosis, is never liable for any injurious consequences which may result from mere errors of judgment, if he has honestly and carefully used such means as in his best judgment are deemed necessary; then, although he may have made a mistake, the consequences of which are hurtful to the patient, he will not be held responsible.

"To charge a physician or surgeon, therefore, with damages, on the unskillful and negligent treatment of his patient's case, it is never enough to show that he has not treated his patient in that mode, nor used those measures which, in the opinion of others, even medical men, the case required; because such evidence tends to prove errors of judgment, for which the defendant is not responsible, as much as the want of reasonable care and skill, for which he may be responsible."

It will seem that the ruling of this court is extremely liberal, in that it holds the physician responsible for damages only in those cases to which he is proven to have been unskilled and negligent. He is not responsible for errors in judgment in those cases in which often the best of men differ, but is required to give his patient ordinary skill and attention, and no more, unless by special contract.—*St. Joseph Medical Herald*.

GONORRHEA: ITS ETIOLOGY, DIAGNOSIS AND TREATMENT.

A letter to two young medical friends, from Dr. L. Coyteaux Prevost. Translated from the *L'Union Medicale du Canada*, for the COLUMBUS MEDICAL JOURNAL,

BY R. M. DENIG, M.D., COLUMBUS, O.

MY DEAR FRIENDS — "Of a hundred given individuals," Lisfranc once said, "at least twenty-five of them either have, have had, or will have blennorrhagia."

It is, then, a very common affection, and I am convinced that more than once since the commencement of your career you have been called upon to bestow on some unfortunate, the aid of your resources and consolations, inspired by sympathy, and perhaps a painful remembrance of your own personal experience.

You are proud of your experience, and are no doubt astonished that I have chosen for the subject of this letter a malady with which you have been so long familiar, and concerning the peculiarities of which you have been so ably and amply enlightened.

I am fully impressed, however, with the idea that there still exist some nooks and corners in this much traveled region which you have not sufficiently explored, and if you will accompany me, we will together see how much that is new we can discover, aided by the light of modern science.

We understand by blennorrhagia, then, a specific, virulent inflammation, having its habitual seat on the genito-urinary mucous membrane of a man or woman, and of which the principal character consists in a more or less abundant secretion of muco-pus.

It is, moreover, accompanied by a frequent and painful micturition — the patient affirming that he is passing "razor-blades;" distressing and annoying erections supervene, especially at night, preventing sleep. The discharge, at first moderate and white, soon becomes abundant and of a yellowish-green color.

Now when any person comes to you with the symptoms above enumerated, you may without a moment's hesitation tell him he has gonorrhea; that is to say, a virulent disease, *sui generis*, contracted by coming in contact with a special virus.

Blennorrhagia is always due to the presence of blennorrhagic virus, and to no other cause; it is a mistake to suppose that this malady can be developed or engendered under the influence of ordinary or extraordinary irritants, other than the one above mentioned. I put myself in flat contradiction with a goodly number of authors who enjoy a high reputation. But what of that? In medicine, whatever may be the authority which addresses us, we have the right—to-day more than ever—to demand that all conclusions as to the etiology of diseases should rest alone on clearly demonstrated facts. I am slow to accept without discussion opinions based upon *a priori* deductions.

Aside from actual contagion, the most frequent causes to which this disease is attributed are: excesses at table, leucorrhea, violent and prolonged coitus, or coitus during the menstrual period.

Well, my dear young friends, I ask you, in all candor, if such were the case, if these conditions were capable of engendering blennorrhagia, do not you think it would be infinitely more frequent than it is? The number of those who expose themselves to the supposed pernicious influence of leucorrhea, the menstrual flow, etc., is so considerable, that if they could cause *chaude pisse*, as the French call it, would there not remain but a limited number of victims for the true blennorrhagia? This pampered agent would occupy only an exceptional position among these numerous other causes of the diseases, and ought to be relegated to a lower plane.

Malgaigne commenced one day a clinical lecture in these words: "Gentlemen, all women are afflicted with the whites, even Mad. Malgaigne." In fact, with women of all ranks, leucorrhea is the rule; and you can easily perceive what a sad fate would be in reserve for every poor mortal if he found himself exposed to contract a gonorrhea every time he exercised his legitimate prerogative, under such circumstances. Every man would have the *whites*, Malgaigne would have been compelled to add. I know of course that much less stress is laid on the influence of leucorrhea than on that of blennorrhagic virus; but the infinitely greater frequency of the former should nevertheless make up the deficiency, and the result be the same.

Then the menstrual flow! Must that be arraigned also? You remember the law enunciated by Moses: "The woman who is suffering from that which comes each month must be separated from her husband during seven days." You know, also, how much importance students attach to this wise counsel of the Hebrew law-giver! Don't they seek

what they ought to avoid? And how many others are students in this respect? And yet how many cases of blennorrhagia have you encountered under these circumstances?

Finally, prolonged and violent coitus, even after an orgie, counts for nothing. They are legion. "*Sine Cerere et Baccho frigit Venus.*" An innumerable throng of beings, transformed by voluptuous indulgence and burning with fever, seek with avidity all that the most unbridled license can offer to the gratification of their sensual refinements; they exhaust, with Ceres and Bacchus, all means within their reach, to alleviate the impetuosity of their inordinate desires. In their delirium they brave everything—leucorrhœa, menstruation, fatigue, insomnia. Survey the next morning this field of battle and what do you find there? Pallid faces, haggard looks, enervation, and perhaps certain faded illusions; but blennorrhagia? Never: at least except some furtive *gonococcus* has treacherously beforehand intruded his presence beneath some rosy and supposed immaculate lips.

And on what proof, pray, do those rely who pretend that blennorrhagia can be produced by any other cause than that of blennorrhagic virus? Is it on the existence of any peculiar symptoms? Certainly not "No differential character," says Langlebert, "enables us to distinguish a blennorrhagia due to contagion—that is to say caused by contact with blennorrhœa muco-pus, from one resulting, for example, from excessive venereal relations with a woman affected with a simple uterine catarrh—or during the menstrual flow. * * * It is impossible to know *a priori*, in any given case of blennorrhagia, in what condition of health the person was who communicated the disease."

If, in every case, the symptoms are the same, or if the variations they exhibit are powerless to enlighten us as to the origin of the malady, on what reposes the assertion that it has not been developed by an impure contact?

Ah! You are ready to exclaim, in certain cases it would be simply absurd to incriminate one of the parties as to its cause. There exist certain circumstances in which everything concurs in prompting a refusal to believe in the possible contamination of the adorable being whom we might be tempted to view with suspicion.

Let us discuss this matter a little, in the utmost privacy and confidence. I address myself to members of the profession; and what I have to say to you possesses a professional character which justifies a liberty of speech which would be altogether out of place under any other

conditions. You are still young, my friends, and your intercourse with what is termed "*the world*," has not afforded you experience ample enough to enable you to know everything in relation to that wonderful and strange organization—that marvel of creation—woman. Much has been vaunted, and justly, of her many fine qualities, her goodness, her beauty, her sweetness; and certainly panegyrists will never be wanting. Shall we ever be favored with a description of the reverse of the medal? Perhaps! But it is not I who will put myself at the head of this dangerous enterprise. Accuse me of pessimism, if you choose, but I acknowledge frankly I have a dread—a fear, of the whole sex. I fear all women without any exception. Whatever be the social condition in which they move, at some moment in their lives they will dissemble; if not through interest, it will be from an instinctive need, inherent in their natures. Francois the First was wont to say, "Women are given to changes, and foolish is he who trusts completely in them." To confer at once and without reserve, on any woman the brevet of innocence and perfect candor, on account of her apparent honesty, or in consideration of the rank she occupies in society, is an imprudence which will involve its author in many deceptions and difficulties.

One day one of my most intimate friends consulted me on account of a discharge which since the evening previous had tormented both his urethra and his mind. I examined him carefully. "My friend," said I, "you have blennorrhagia."

"Impossible!" he replied, with apparent candor and much assurance.

"Why so? Princes and kings are exposed to it as well as the humblest of their subjects."

"But, doctor, I have relations with but one woman."

"Very probably. You know what the distinguished English poet says of Don Juan?

'Some said he kept a mistress, some said two,
But for domestic trouble, one will do.'

"Suppose we substitute *clap* for domestic troubles, how will that suit you? I don't believe, my friend, in spontaneous generation."

"A truce to your pleasantries, doctor. I have told you the truth; I have been with but one woman, and have the utmost confidence—in fact am absolutely certain I am the only one to whom she grants similar favors."

"Of course! Of course! But do you know, my friend, that no man ever has the first favor of a woman? It is like a pun; no one need flatter himself it is original, for he is sure to find on searching that some one has made it before."

"But listen. I will put myself at your discretion, and impart a confidence which will certainly astonish you. The person to whom I refer is no other than Mademoiselle B——."

I am free to confess that I felt for a moment somewhat disconcerted. I knew perfectly well the young lady whose name I had just heard mentioned. She belonged, in fact, to one of the most respectable families in an aristocratic neighborhood; was young, accomplished, handsome, a recognized leader among a large circle of choice associates. It was sufficiently repugnant to me to believe that the *auge-si-pur* had consented to grant her favors to my happy young friend; but my inexorable logic forced me to the conclusion that she was even then suffering from an attack of blennorrhagia, contracted in the arms of some previous lover, which did seem extremely improbable. On the other hand, I had no reason to doubt the truthfulness of my friend's statement, who assured me he had not been exposed elsewhere, a falsehood which, under the circumstances, would have been without motive, and altogether useless. I was half conquered. I did not, however, take in my flag, but simply lowered it to half mast, and waited for future developments.

I wrote a prescription and we separated.

I suppose the partisans of the dual nature of blennorrhagic origin, would have had no trouble in disposing of this case, and would have scouted the idea of the existence of gonorrhea in the person of a young girl, so pure, so *chaste*, belonging, as she did, to so distinguished a family, and a member of such *recherche* society. "She has made a *faux-pas*—it is the first," they would have said, "and will not be repeated. This unfortunate young man has the clap, it is true; but the victim (not the young man but the other) has perhaps had leucorrhea, who knows? Perhaps also this unfortunate libertine has violated the law of Moses; or again, he may have partaken too freely of the wine cup, which has betrayed him into the commission of this imprudent act, which he so sincerely regrets."

I acknowledge, my friends, I might have been caught in the meshes of these idle conjectures, had not circumstances, quite peculiar, put me on the right track. This candid young girl—had she really, then, blen-

norrhagia? I am the family physician, and was called on to treat her. She was ignorant, poor girl, of the nature of her disease, and I think would have preferred death to allowing her physician even to suspect the true nature of affairs; but the diagnosis was easily and readily made; no element was wanting. I learned later the name of the most guilty one in this *joint stock company*. He was still under treatment after the blennorrhagia of his victims and allies was cured.

Again: An individual afflicted with a painful urethral discharge presents himself, having sexual relations with but one woman. The physician examines the latter and discovers no symptoms of blennorrhagia. He concludes, quite naturally, that his patient has contracted gonorrhea, due to other irritating causes foreign to the presence of blennorrhagic virus. And yet nothing is further from being proven. In the first place, I do not subscribe to the popular adage, that a woman gives only what she herself has. It may easily happen that she gives her lover (and why not her husband?) a clap which she does not herself have, without disproving a whit the theory we advance. Only, this necessitates the clandestine cohabitation of a third party, who, contaminated himself, deposits in the genital organs of the woman a virus seeking whom it may devour. The unfortunate individual here is the next one who arrives. The woman, favored by a fortuitous condition of non-receptivity, transmits the virus without suffering herself from its presence.

Again, it may be possible for the women to be suffering from a blennorrhagia, and the physician has been wholly unable, even after a supposed careful examination, to detect it.

It is more difficult than you imagine to recognize a blennorrhagia under all circumstances. The existence of a vulvitis, or vaginitis, accompanied by a muco-purulent discharge, furnishes only a presumptive evidence, for it presents no decided characteristics in itself which distinguish it from other discharges produced by uterine catarrh, or traumatic vulvo-vaginitis. On the other hand, the absence of all vaginal secretion at the moment of examination does not preclude the existence of a blennorrhagia, since the pathogenetic symptom necessary for the latter must be sought for in urethritis.

In a general way we may assert that idiopathic or spontaneous urethritis is rarely found in women. Ricord, Cullerin, Rolles, Tardieu, Martineau, have asserted, with all their scientific authority, that if in an inflammation of the vulva, or vagina, there exists also a urethritis, we may

affirm with absolute certainty the contagious nature of the vulvo-vaginal inflammation. It is of the first importance, then, in all cases where a true diagnosis is imperative, to be able to recognize this urethritis which constitutes a sign so valuable in the detection of a contagious disease. The important point is to have the vulva well exposed to the light. To accomplish this the patient should occupy a gynecological chair, or be placed across her bed, opposite a window, the knees well flexed on the abdomen, and the thighs separated as much as possible. In this condition a complete and exhaustive examination can be made of the urethra, and the existence of muco-pus be detected by a careful manipulation, carrying the finger as far as possible towards the bladder and bringing it along the course of the urethra to the external meatus.

Again and lastly: A woman confesses to having had a blennorrhagia, but claims that she has long since been entirely cured. She asserts most positively that she has not since been exposed to a renewal of the disease, and you may have every reason to give credence to her statements. Notwithstanding all this, her new lover, who also denies having foraged in foreign pastures, finds himself before long suffering from a suspicious and painful urethral discharge.

Should you conclude from this the blennorrhagia here present in both parties is due to any cause apart from contagion? Not in the least. Urethritis is a disease proverbially rebellious in women, and often persists with all its contagious qualities, long after the disappearance of the vulvitis and vaginitis has induced the woman to believe herself cured beyond any possibility of communicating disease. Guerin, Gosselin, Martineau, assert that they have known this to occur even after three or four years of supposed immunity (?).

Blennorrhagia may remain localized a long time in the follicles of the vulva or urethra, unrecognized by either the patient or physician. Under the influence of sexual relations frequently repeated, the fire smouldering in the ashes is rekindled, and the disease undergoes inflammatory recrudescence, much to the astonishment and chagrin of both parties concerned. Tanglebert asserts that the same thing occurs not infrequently in the other sex.

These facts have nothing in them which should astonish us, since recent micro-biologic investigations have put us in possession of the true nature of that virus. Blennorrhagia is undoubtedly a microbic disease, and all parasitic affections may remain in a dormant state for a longer or

shorter time, retaining nevertheless *in posse* all their injurious qualities when resuscitated by some fortuitous or favorable condition.

Blennorrhagia is without doubt susceptible of a perfect cure, which occurs in the largest number of cases. Where the disease subsequently shows itself, there has been either a new exposure or a latent microbism has been aroused to activity by some determining cause. I am firmly of the conviction that not unfrequently this latter condition of things has been overlooked, or not suspected; and a renewal of the symptoms even in men has been attributed to causes which had no real agency in the matter. In a word, I believe that blennorrhagia is transmitted only by contagion. No irritant action of the sexual organs can give rise to or produce the disease in the absence of the true virus.

Blennorrhagia is a local affection, is born, so to speak, lives and dies where it has originated without becoming generalized. However, it is still sometimes accompanied with complications at a distance from its seat, the cause of which is still obscure, and which are worthy of consideration; we refer to arthritis and blennorrhagic conjunctivitis, the former of which is sufficiently common with men. I say with men, for this complication seems to be extremely rare with the other sex. In nine years Cullerin has observed it in only three cases in women. Guerin has met with it only once during a period of four years. Rollet, Diday, Martineau, have never seen it.

What is the cause of the difference in the frequency of the recurrence of this complication in the two sexes, I am unable to say, and the explanations of authors who have tried to solve the query are quite unsatisfactory.

Blennorrhagic arthritis offers a strong analogy to sub-acute articular rheumatism; and if you do not bear in mind the possibility of this strange manifestation, you will often overlook the true source of this inflammatory affection which may supervene in any case.

You know that one of the prominent characteristics of acute articular rheumatism is its proneness to affect in succession the various joints. Now blennorrhagic rheumatism is rarely if ever poly-articular. Recollect this, and when you find yourself in the presence of inflammatory phenomena, seated exclusively and during several days in a single articulation, most frequently the knee, be on your guard; suspect at once a blennorrhagia, which is often concealed, and satisfy yourself by rigid examination.

The same remark applies to conjunctivitis which often supervenes in

gonorrhea. Purulent ophthalmia is exceedingly rare in the adult, if it ever exists apart from that produced by the inoculation of blennorrhagic pus; so when you find tumefied eyelids, accompanied with purulent secretion from the conjunctivæ, in all probability a gonorrhea has found entrance there. Examine for yourselves, and if you do not find the presence of blennorrhagia in the individual, you may rest assured that either his fingers, or those of some one else, contaminated with gonorrheal virus, have been in contact with them.

In blennorrhagic arthritis the synovial membrane is most generally the seat of the disease. The serous exhalation which is the result, is poured into the joint, giving rise to an hydrarthrus—often quite considerable, and very difficult to cure. I have recently had occasion to observe a very remarkable case of this malady. This was in the person of a young man, married for some years, suffering, I was told, with inflammatory rheumatism of a very painful character. I found him nailed to his bed by a considerable tumefaction of the right knee, exceedingly sensitive to the slightest pressure. For the three days during which the attack had existed, the inflammatory manifestation was confined to a single articulation. I learned from him also, that every year during the past ten years, he had suffered from a similar attack following gonorrhea, which lasted always from three weeks to a month and was always located in the left knee. This time, however, it was the right, and subsequently invaded the ankle, the arm and the shoulder of the same side. I at once divined the source of his trouble. The patient readily acknowledged that he was suffering from an attack of blennorrhagia.

Whatever authors may say to the contrary, the discharge does not cease on the appearance of the synovitis, a subject to which Fournier has done ample justice. It may diminish a trifle, owing perhaps to the enforced repose rendered necessary by the inflamed joint, but it never disappears entirely; so much the worse for the partisans of metastasis. Different theories have been formulated to account for this articular complication. Some, Thiry, Guyon and others for instance, regard it as simply an accidental complication of blennorrhagia, which favors perhaps its development—but never has a causal effect—a *post hoc*, not a *propter hoc*. Others, with Heuter and Fournier, consider blennorrhagia as purely of urethral origin, due to the existing urethritis. It is the same, they say, as we often witness as the result of catheterism. Barth refuses to accept this theory, and denies that urethritis has the power of developing rheumatism, even in the persons habitually subject to that disease, and

moreover these habitual rheumatics are less liable to it when having blennorrhagia than others. Nor does he concur in the belief that it is a mere coincidence, as in that case it would be vastly more frequent in blennorrhagia than in any other disease. For him, the articular manifestation should not be considered true articular rheumatism, but rather as an arthritis of an infectious nature, belonging to that numerous class of *arthropathies* of infectious origin. Lorain and Lasegue admit also its infectious nature, depending upon purulent absorption by the blood from the inflamed urethral mucous surface. After all, we know but little of this pseudo-rheumatism, or of rheumatism itself.

We pass on to the consideration of that other complication, known as purulent or gonorrheal conjunctivitis, which is a truly formidable affection, and one which may complete its work of destruction in twenty-four hours if not jugulated at the moment of its appearance. Neissier has clearly demonstrated the existence of the *gonococcus* in the discharge from gonorrheal ophthalmia. This complication evidently results in adults from inoculating the eyelids by the aid of the fingers. Its existence, where it is most frequently met—in the new-born, is readily accounted for when the mother is suffering with blennorrhagia. One thing, however, astonishes us—as De Wecker remarks—namely, the rarity of the affection in view of the facility of inoculation, and the great frequency of blennorrhagia. How does it also happen that, like arthritis, it is so seldom met with in women? It is almost unknown in the Toureine Hospital; and Martineau assures us he has not observed a single case in seven years, among 2,000 female patients.

A word only on the subject of the treatment of blennorrhagia in general and I am done. In the first place, when any unfortunate individual presents himself before you with a *chaude-pisse*, do not fail to insist on the following conditions:

1st. *No alcoholic drinks*, and mention especially *gin*, on account of the popular prejudice that gin is rather beneficial than injurious in gonorrhea. Remove this mistaken idea from the mind of your patient, and proscribe remorselessly wine, gin, brandy, whiskey, beer, especially beer. I have a friend who assures me that a single glass of this beverage will invariably renew the discharge or increase it in quantity.

2d. *No women*. Let Venus grant to wounded Love time to dry his tears. Be absolute on this point. Avoid everything leading to erections. These come chiefly at night, so order your patient to have in readiness a large glass of very cold water in which he can plunge the penis at the

first threat. This is a very efficacious method of silencing the protestations of this imperious member. No feeling or pressing the diseased organ to ascertain whether the discharge has diminished. Try to induce your patient to brood over his trouble as little as possible; constant dwelling of the mind on it renders a cure almost impossible.

As to therapeutics, you have only the embarrassment of choice. I prescribe usually extract of cubebs and bals. copaiba, with spirit of nitre, after the inflammatory stage has been subdued by salines and tisanes, and sometimes a grain or two of camphor at night when chordee threatens. Be cautious in the use of injections, especially during the inflammatory stage; the one to be used, *par excellence*, when the time comes, is a solution of corrosive mercury. Gonorrhea is due to the presence, as we have said, of a specific virus, and must be exterminated by a specific germicide. We have this in corrosive sublimate. This therapeutic agent, moreover, was employed against blennorrhagia even before the microbial theory was thought of. In 1805, Russ, of Strassburg, used injections in the proportion of one to ten thousand, as an abortant treatment. It is, however, only during these last few years that this parasiticide has attracted the attention of physicians occupied especially in the treatment of venereal diseases. Tauti in Italy; Diday, Blondeau, C. Paul and Martineau in France, are among those who have strongly endorsed this new method of treatment.

In women, notably, Martineau has obtained marvelous results by the use of urethral suppositories containing one-thirtieth grain of bi-chloride of mercury. In blennorrhagic vaginitis he uses injections of the same in the proportion of one grain to one thousand of water by means of which he bathes the vaginal cul-de-sac once a day.

I may say, in conclusion, that I have derived the most gratifying and satisfactory results, in a recent case, by the use of corrosive mercury in one part to twenty thousand, which had proved refractory to various other means. Far from me the pretension of according to one isolated fact a significance it does not deserve, but all things have a beginning. Try it yourselves, and you will not long be deprived of an opportunity. You can find corrosive mercury at any pharmacy, and clap every place—I was going to say in every family, and perhaps nearer home than even that.

THE TREATMENT OF PLEURISY IN CHILDREN.—Dr. Weiderhofer has recently studied this subject, chiefly from a clinical standpoint. The following are the main points of his paper, as given by the *Arch. of Ped.*:

The younger the child the more difficult of diagnosis is pleurisy. The disease may be entirely overlooked without a very minute examination. After the exudate has formed the diagnosis is somewhat less difficult. Then the child breathes more superficially, there is a febrile movement and cough, which may last several days. The frequent and superficial respiration are the more important indications in making the diagnosis. If there is no exudation in the pleural cavity, the child will lie upon the diseased side. As to the physical signs, at first there is general bronchial respiration, gradually there is dullness on percussion and diminution of the respiratory murmur. Should the exudation be abundant the diagnosis may be readily made, but should it be limited to a small area at the base of the pleura the diagnosis will be difficult. The sensation which is yielded by percussion is believed to be of greater assistance in forming a diagnosis than the information which is obtained by auscultation. The prognosis of this disease is usually favorable. Thoracentesis will be necessary in case the exudation is not absorbed, and especially in cases in which it is so abundant as to occasion troublesome dyspnea to the patient. Purulent accumulations rather than serous or sero-fibrinous ones cause trouble of this kind, and can usually be correctly diagnosticated in those cases in which an exudation persists longer than fifteen days, the temperature reaching 104° F., morning and evening, while the child steadily emaciates. The crucial test is, of course, an exploratory puncture. The treatment of purulent pleurisy by aspiration is not followed by the best results, for, in a few days, another deposit of pus has taken the place of the former one. The author believes that it is best treated upon the same principle which governs the treatment of abscesses. An incision, sufficiently large, is made between the fifth and sixth ribs, the pus is evacuated, a drainage tube is introduced, and an antiseptic dressing is applied. The patient is usually cured in from two to three weeks. Should the operation be deferred until an advanced period of the disease the pleural cavity must be washed out systematically with a solution of salicylate of soda or of thymol. Phenic acid solutions are dangerous, and numerous cases of poisoning have followed their use. Unless the operation is performed early there will be deformity of the thorax. If the purulent deposit is left to itself it may point somewhere upon the abdominal or thoracic wall, and will be revealed by swelling, fluctuations, and inflammatory edema. In most cases of this character there is a fatal issue.—*Med. Record.*

MEDICINE.

VOLITION AND COUGHING.—(Thomas F. Rumbold, M. D., of St. Louis, in the *Maryland Med. Jour.*)

There is far more probability of an anodyne application relieving a little finger that is benumbed by a blow on the elbow, than that a cough will remove the sensation in the throat that is caused by an irritation due to inflammation or to a lodgement of a secretion behind the soft palate.

I have known patients cough, on an average, ten times every five minutes for two hours in the morning, making two hundred and forty spasmodic efforts to relieve the throat of tickling sensations. Now, this is tiresome to a weak individual and the relief of one-half of their efforts may be sufficient to prevent the throat becoming inflamed and thus prevent the lungs being implicated in the disease. If a healthy individual coughs two hundred and forty times in two hours every morning—not to take into account the very frequent coughing through the day that is done by every such patient—he will, in a few weeks, have his throat so highly inflamed that he may require medical aid for its relief.

A good method to help one to control the cough, is to mark each cough on a card, preserve this card, and endeavor to decrease the number of coughs each day. I have known patients to decrease these efforts seventy-five per cent. One patient coughed one thousand and eighty-five times the first day's tallying, on the next day he coughed four hundred and fifty times, on the next, only two hundred and twenty times. This may seem to some to be trifling work, but the result is always beneficial to the cough and to the strength of the patient. Some patients have tried to control the cough without marking each effort down, but they are not certain as to the degree of decrease or increase of the cough; there is no doubt that a person will be more certain of success in controlling his cough if he marks every effort on a piece of paper; under these circumstances the mental effort will greatly assist in resisting the sensation of tickling in the throat.

THE THERAPEUTICS OF ASTHMA.—Within the past few years the interest of medical men in the subject of the treatment of asthma has received a fresh impetus from the birth of a new theory of the pathology of the affection. As is well known, Hack and a number of other observers have drawn attention to abnormal changes in the turbinated bones, and in the mucous membrane of the nose and the pharynx, as the chief factors in the causation of a large percentage of the cases of asthma. Hack

laid particular stress on swelling and hypertrophy of the inferior turbinated bones, and recorded several cures brought about by cauterizing or removing the hyperplastic tissue. Since the publication of this article, specialists and general practitioners have, with the aid of highly magnifying reflectors, seen hypertrophied turbinated bones in many an asthmatic patient, which there was a great temptation to reduce, either with some ingenious instrument, with the galvanic cautery, or with a powerful escharotic. Although the results have not been so gratifying as Hack's, they have gone far toward affording an apparent verification of this theory; for, if the so-called hypertrophied turbinated bones could be detected at first only with the aid of magnifying reflectors, it was not long before they were sufficiently hypertrophied to be distinct even to the naked eye.

The pendulum, however, is beginning to swing back, as is evident from a recent lively and protracted discussion at several consecutive meetings of the Berlin Medical Society. A number of speakers took part in the discussion, and there seemed to be a consensus of opinion that cases in which asthma was benefited by cauterizing the nasal mucous membrane or the turbinated bones were extremely rare. Such treatment, it was said, should not be employed until a careful examination had been made with a sound, the parts having been made anesthetic with cocaine, and an area discovered a touch upon which would call forth an attack. Scadewald broached a novel method of treatment, based on his no less novel theory of the pathology of the disease. He maintained that bronchial, or true, asthma was due to a neurosis of the trigeminal nerves, and should be treated by faradization of those nerves, the application being made during an attack, as if made in the intervals, they would not call forth a paroxysm. Lubinski emphasized his previous remarks as to the benefit to be derived from inhalations of pyridine, but the drug must be used with caution, as disagreeable and alarming symptoms may follow its injudicious use. Amyl nitrite, nitro-glycerin, and sodium nitrite act in the same way as pyridine, but all these remedies find their more appropriate application in cardiac asthma.

If any drug deserves the title of a specific in this affection, it is potassium iodide. The remedy was first recommended in asthma by Trousseau, but this use of it fell into oblivion for a number of years, to be only recently restored by the publications of Leyden and Germain See, the latter of whom recommends its administration with lactucarium. Potassium iodide is of great service also in the purulent bronchitis which

occurs as a sequel to asthma. In many cases of this condition the various balsams are efficacious; and Lubinski has observed excellent results from the use of Peruvian balsam combined with myrrh, the former in doses from a grain and a half to three grains three or four times a day. If there is really a nasal affection, it should be treated according to its character, and not on any far-fetched theory of its etiological importance. But, in the treatment of asthma, it is of the greatest moment to distinguish true, or primary, asthma—by no means a common affection—from that which is secondary to disease of the heart and lungs. We need scarcely to say that we have had only the former in view in this writing.—*N. Y. Med. Jour.*

TREATMENT OF ACUTE DYSENTRY.—The inflamed edematous condition of the mucous membrane, and subsequent obstruction to passages from the bowel, is well known. Remembering the relief often obtained from the application of hot water to inflamed surfaces, and the beneficial effects of solutions of bi-chloride of mercury upon ulcerated surfaces, particularly of mucous membrane, the thought occurred to me that if I could carry the hot water into the bowel, allowing it to flow back in sufficient quantity to remove for a distance from above all fecal and offending matter, I should accomplish two important objects—*i. e.*, relief of pain, and prevent absorption of poisonous matter up into the blood, the antiseptic properties of the bichloride aiding in this latter object. Upon this I acted, using a soft rubber tube attached to a Davidson's syringe, passed carefully through this sensitive inflamed tissue, so as to carry the liquid above the rectum into the colon. The patient was placed on his side, with an oil-cloth beneath him, and four or five quarts of water as hot as could be borne were injected and allowed to flow back with whatever substance had accumulated or remained in the bowel above. When the water returned clear, then a quart or more of the solution of bichloride, about 1 to 10,000, was injected and allowed to return in the same manner. The effect was immediate relief of pain and tenesmus. A suppository of opium, one grain, was given and retained, and, for the first time after the attack, the patient slept seven hours, awaked refreshed, could take some food, and, if perfectly still, was free from pain. In about twelve hours slight return of pain was felt, and the same treatment repeated. This treatment was continued, with the bichloride solution, four times, and the hot water alone was used for four or five days more, with suppositories of one grain of opium, morning and night, with per-

fect recovery, no medicine being administered by the stomach, except one-grain doses of quinine, three times per day.—Dr. B. A. Fordyce, in *Buffalo Med. and Surg. Journal*

NUX VOMICA—INFLUENCE OF AGE UPON ITS DOSAGE.—(Dr. J. H. Musser, in *Thera. Gaz.*)

1. The effects of nux vomica are in inverse proportion to the age of the patient; the susceptibility increases with age.
2. The usual doses of the tincture indicated in the text-books are inadequate and do not represent the usual dose of strychnine.
3. It is a powerful and rather transient stimulant.
4. The best therapeutical effects can be secured in many cases only by pushing the drug almost to the physiological dose.
5. The system soon becomes accustomed to its use, and the dose must be increased.
6. The good effects in dyspepsia are largely due to its power to heighten reflex excitability.

HOW TO ADMINISTER TINCTURE OF IRON.—The following method of prescribing tincture of iron is recommended as being palatable, elegant and altogether satisfactory. Prof. Goodell, of Philadelphia, terms it "lemonade iron."

R Tinct. ferri chlor.....{3iv
 Acid phos. dil.....{3vj
 Spts. limonis.....{3ij
 Syr. simplicis ad.....{3vj M.

Sig. Two teaspoonfuls in water after each meal. The spirits of lemon is preferred to the syrup of lemon as the latter would render the mixture too acid.

DONT'S FOR HOSPITAL AND PRIVATE NURSES OF THE SICK.—

1. Don't have a light constantly burning in the sick-room, unless the patient is timid and wishes it, or requires constant attention, or the physician orders it for some good reason of his own.

Never burn a coal oil lamp in a sick-room, if it can be avoided; sperm or wax-lights are preferable lights in a sick-room.

If a light must burn all night in a sick-room, place it near a fire-place or flue, and secure a little fresh air to nourish the light as well as the patient where practicable.

A little more air will be requisite for the night gas jet and patient, than for the patient alone in day time.

2. Ventilate every sick-room moderately night and day, but never with a draft of air that can strike the patient.

Consult the attending physician as to the amount of air and the place to let it into the room.

3. Remove, or burn, or disinfect at once all offensive matters, but don't burn anything in the patient's room.

Disinfect with corrosive sublimate, carbolic acid or chlorine, or other disinfecting compound recommended by the physician.

Disinfect the commode, or chamber vessel, before and after it is used.

Cover everything offensive and everything the patient is to drink securely.

Never leave a glass of medicine or water for the patient to take not securely (air tightly) covered.

Japanese paper, blotting paper, or plain white paper, slightly moistened and held down securely by a plate, or saucer, will make a good protection lid for vessels without close covers.

Remember that fluids absorb the sick room effluvia and they may be so employed as to either purify or poison the patient according to the intelligence of the nurse.

Burning coffee disinfests, so does the vapor of thymol, glycerine and sulphur. Charcoal, copperas and lime are good absorbents.

4. Don't put a patient in a room previously occupied by another patient, especially the room of a patient who has had typhoid fever, phthisis, pneumonia, erysipelas, syphilis, diphtheria, scarlet fever, cholera, or any other fever before the room has been fumigated well with burning sulphur, flushed afterward with fresh air and the walls and wood-work washed with one to three per cent. of corrosive sublimate.

Never use bedding or bed-clothing of any patient for another until after renovation.

The only safe rule is to never use a room or bedding of any patient for another until they have been thoroughly and antiseptically renovated and cleansed.

In using antiseptics disguise them with the milder or more agreeable one, so as to impart an agreeable odor.

Aromatized vinegar makes a handy and cheap disinfectant and antiseptic in emergencies when the better ones cannot be had. It is ancient and tried.

5. Make the sick-room cheerful as you can with flowers and pictures and words that please the patient.

Don't regulate the odor of flowers, or style of pictures or conversation to your taste unless in accord with the patient's likes.

Change the place of pictures, furniture, etc., to destroy the monotony, and swap with neighboring rooms at times.

You don't want a profusion of flowers in a sick-room and they should be managed like the light in regard to air. Many flowers rob a sick chamber of vitalizing air.

6. Don't have the room temperature below 60° F., or above 70° F., unless specially directed otherwise by the physician.

7. Don't make any needless or avoidable noise in going about a sick-room, attending the fire or moving furniture, etc.

Don't whistle, or hum a tune or thrum on the foot-board of the bed, or on anything else.

8. Be easy and natural and quiet in all your movements about a patient. Don't be fussy.

9. Don't call the patient's attention to his malady by discussing or expressing sympathy. Be kind rather than over sympathetic. Cultivate the patient's pluck and inspire courage by a cheerful, matter-of-fact hopeful manner.

Let the patient see by your manner that you are not alarmed.

Don't show alarm or fear for the result in the case you are caring for.

Express regret in a hopeful way, rather than by depressing and hopeless sympathy.

Be kind, tender, comforting and hopeful in your demeanor, and this will strengthen the patient.

10. Don't discuss bad medical news or calamities of any kind.

11. Don't gossip about the other patients in the hospital. Appear as ignorant as you can as to the suffering and fate of the other patients in the hospital, but answer questions candidly where you cannot avoid answering.

12. Don't discuss in an unfavorable manner the physician's treatment, or name any other physician whom you think might have done better.

13. If you have the Christian's faith, cheerfulness and fortitude, and every nurse should have these qualities whether professing Christians or not, impart them by your manner and an occasional, but never an obtrusive word.

Don't obtrude, unsolicited, the weighty and perplexing question of

the soul's salvation upon a mind harassed, weakened and made morbidly apprehensive by disease. The fate of the future life is too weighty and awful a subject usually for the seriously sick to discuss.

14. Hope may be inspired in God's mercy, but don't ask a dangerously sick person if he or she is ready to die.

15. In short, don't do anything with or towards patients that will disturb them, or irritate them mentally or physically, if you can avoid it.

Don't differ from them on politics, or religion.

Don't deny them anything that would please and not harm them.

Don't promise them anything you cannot give them, or might be kept from giving them, or doing for them by the physician.

Don't do anything for your patient or about him you are not sure the medical attendant would not direct or approve.—C. H. Hughes, M. D., in *Med. Review*.

THE PROGNOSIS IN VALVULAR AFFECTIONS OF THE HEART.—Probably in nothing else is the young practitioner so much at sea as in the matter of prognosis, or so frequently the subject of derision at the hands of the laity. The importance of prognosis as an element of medical knowledge is often overlooked by authors and teachers, yet scarcely a day passes that a physician is not met with questions as to prognosis that demand for their solution a deep knowledge of the probable course, the effects, and the duration of some disease, and this is particularly true of diseases of the heart. A lad is brought to us, for example, with a damaged heart, and our advice is asked as to what course of life he ought to pursue. Shall we entail upon him a life-long course of idleness and incapacity? Another desires to marry. Shall we dissuade him from taking this step? A third is leading an active business life. Shall he be advised to retire and perhaps live in obscurity and comparative poverty the rest of his days—which may be longer than we predict? In view of the importance of such questions, the profession can but feel grateful to Sir Andrew Clark for presenting, at the last meeting of the British Medical Association, the results of his vast observation, as is to be found published in the association's "Journal." What makes his remarks of particular value to the general practitioner is the fact that they treat of cases observed in private practice for a long term of years. More than this, they throw a ray of hope and encouragement into the darkness of despair brought about by the teaching of Laennec and the subsequent pathological school. The very title under which they are grouped is comforting—"Cases of Valvular Disease of the Heart known to have existed for over

Five Years without Causing Symptoms." He has tabulated *in extenso*, with great care and precision, all the cases of which he has notes, occurring between 1873 and 1886—684 cases in all. Apart from the cardiac symptoms, the persons applied for advice on account of the most varied manifestations. In selecting his cases, the author excluded all instances of mere "murmurishness," all of murmurs that were inconstant and intermittent, all of murmurs occurring within the pulmonary and tricuspid areas, and all of murmurs, of whatever kind, in patients who, independently of cardiac examinations, had subjective or objective symptoms of heart disease. Attention is drawn to some "afternoon" cases, as the author styles them (eleven in number, not included in the tables), which very graphically illustrate the long duration of cardiac disease without characteristic symptoms. We can refer only to two of them.

In one instance, in 1842, the house-governor of one of the largest hospitals in London was rejected by a life insurance company on account of a damaged heart, and was told that he might not live longer than six months. In consequence of this he was superannuated, on full pay, by the hospital committee. In 1854 this person consulted the author for indigestion, and at that time a loud, rasping systolic murmur was heard, not only in the mitral area, but all over the left side of the chest. Beyond the symptoms of indigestion, due to the patient's indiscretions, the murmur was the only evidence of cardiac disease. Without being particularly careful, he continued to live, work, and enjoy life until 1874, when, at an advanced age, he died of an acute bronchitis.

In another case, that of a lad sixteen years old, there was enlargement of the heart, a loud systolic bruit was heard in the mitral area, there were direct and regurgitant aortic murmurs, the impulse of the heart was diffuse and heavy, the cervical veins were rather full, and the pulse was somewhat jerking and collapsing. The boy said he suffered nothing, but felt quite well. The family had been told that he was the subject of grave heart disease, and the consultation had been sought for merely to ascertain by what means his life could be prolonged as much as possible. They were advised to follow out their intention of giving the lad a university education, which they did. This was fifteen years ago, and now the subject of the consultation is the incumbent of one of the largest parishes in England, and continues to pursue an active, useful, and comfortable life.

Sir Andrew Clark expresses himself to the effect that organic murmurs of the heart, although firmly established and lasting for some years,

may eventually disappear, and cites several cases illustrating the fact. What are the conditions which justify a favorable prognosis in a given case of valvular heart lesion? According to the author, they are the following: (*a*) good general health; (*b*) proper habits of living; (*c*) no essential liability to rheumatic or catarrhal affections; (*d*) an origin of the valvular lesion independent of degeneration; (*e*) an existence of the valvular lesion for over three years without change; (*f*) sound ventricles of moderate frequency and general regularity of action; (*g*) sound arteries, with a normal amount of blood and tension in the smaller vessels; (*h*) a free course of the blood through the cervical veins; (*i*) freedom from pulmonary, hepatic, or renal congestion. To these must be added obedience to properly adjusted rules of health, which, however, need not interfere with the performance of the usual duties of life.

The author sums up as follows: 1. There are many persons with long-standing disease of the heart engaged in the active business of life, who, without any symptom of heart disorder, have enjoyed good health and have reached an advanced age. 2. The mitral regurgitant murmurs so often encountered in chorea disappear for the most part within eight or nine years of the attack. 3. Valvular inflammations and their effects, arising in the course of rheumatic fever, do sometimes disappear and leave behind no clinical evidence of their former existence; this occurs, for the most part, in the young, but also sometimes in the middle-aged. 4. The signs of valvular defects arising out of degenerative changes of middle life do also, on rare occasions, disappear, and, when circulatory and respiratory disturbances accompany their beginning, they sometimes subside and admit of apparently complete readjustment. 5. As there must be, in the histories, habits, occupation, and surroundings of patients with valvular disease, conditions which in one case bring about secondary disorders, and in another exempt from them, these differences should be searched for and made capable of application in practice. 6. Any systematic and critical study of the subject, likely to lead to practical issues, could be undertaken only by the Collective Investigation Committee, and not by it unless actively assisted by experienced general practitioners who possess in a special manner the knowledge necessary to the end in view. 7. A joint inquiry of the kind proposed, conducted with due patience, discrimination, and accuracy, would greatly extend our knowledge of the natural history of diseases of the heart, and largely increase our means of assisting those who suffer from them.—*N. Y. Med. Jour.*

HEROIC DOSE OF TURPENTINE IN CROUP.—In an obstinate and dangerous case of diphtheritic croup, which had extended into the larynx, after painting with boracic acid, and subsequently with a chloric acid application, without benefit, the child's condition becoming worse and worse, Dr. Lewentaner, of Constantinople, before resorting to tracheotomy, remembering a paper by Demlow in which turpentine was recommended in these cases, determined to give it a trial, and so administered with his own hands a teaspoonful of the pure oleum terebinthinæ, giving after it some warm milk. In a quarter of an hour the labored laryngeal breathing had given way to normal respiration sounds. That night the child slept well and was quite free from the brassy cough which had previously been present. The next morning he was quite lively and was found playing with his toys. All trace of false membrane had disappeared from the pharynx, which merely presented a reddened surface. Convalescence was rapid and uninterrupted. The turpentine, however, caused an eruption on the face, trunk and extremities, having much the same appearance as the rash of measles, but of a brighter red. The spots completely faded in two days, and were followed by no sign of desquamation.—*Lancet*.—*Med. News*

COCA AS A TONIC.—(Prof. Marius Odin, M. D., Nice.)—Madame de G., of Austrian nationality, 25 years of age, married, no children; average constitution, lymphatic temperament; sent for me February 2, 1884. I was struck at first sight with her pallor; her skin and the mucous membrane of her eyelids and lips were quite colorless. She complained of weakness and general atony, cephalalgia, dizziness, tendency to lipotynic, caused by sorrows, sitting up late at night, and generally depressing influences. There was gastralgia, with alternate constipation and diarrhea. Menstruation was irregular, and an abundant leucorrhea was accompanied with gastralgic exacerbation. Her pulse was weak and depressible; there was a blowing sound with the first heart-beat; very accentuated in the carotids. On auscultation I found weak respiratory murmurs, much prolonged expiration; dry and jerking cough. There was insomnia and a tendency to night sweats. Everything had been tried—tonics of all sorts, arsenic, iron, quinquina could not be borne; hydrotherapeutics had given no results.

I prescribed the Vin Mariani Erythroxyton Coca, from which I had had much satisfaction on several previous occasions, but which I had never used alone. Want of appetite being one of the chief symptoms,

and this keeping her general condition at a low ebb, I gave her a few doses of rhubarb, which, however, modified the situation but little. From that time I prescribed the Vin Mariani in doses of a claret glassful morning and evening, a quarter of an hour before meals.

At the first dose Madame de G. complained that it increased her dizziness. I assured her that this was a salutary and even necessary first effect of the medicine, and she consented, not without reluctance, to continue the use of the Vin Mariani. At the end of eight days there was a notable amelioration. Appetite appeared, food was taken, and the digestive functions were becoming more regular—day by day. I then advised the patient to increase the dose by two more glasses per day, either after meals or between—whenever she had to undergo some exceptional fatigue. She has since then resumed her daily occupations, and tells me, thanks to the medicament taken at proper times, she can bear, without fatigue, long conversations, and, at the same time, her vocal powers have acquired ampler development. At the end of a month's treatment, her state was most satisfactory; there remained a slight blowing with the first heart-sound, which, however, was disappearing, and was not at all perceptible in the carotids any more.

This observation seemed to me very interesting and conclusive in this respect, viz: that it shows the action of the Vin Mariani, when administered without any other medicament, and, what is no less interesting, it shows its useful effects upon the vocal organs—a fact first determined by the eminent specialist, Professor Charles Fauvel, who has given to it the name of "Tensor of the Vocal Cords."—*Gazette de Therap.*

PREVENTION OF SCARLATINA MALIGNA.—Before an English medical society Dr. Michie read a paper on the use of the vapor of an impure preparation of carbolic acid in the treatment of scarlet fever during a severe outbreak which occurred some time previous in the fishing village of Cove. He held that his treatment at once reduced the malignancy of the disease, and soon removed the poison from the place. The number of cases was thirty in all, mostly children of school age. The outbreak commenced in a very grave and fatal form, and, in the absence of eruptions, could only be designated as diphtheria of the worst type. The first three cases died on the second day without any eruption, the next two on the fourth day, when a dark, hazy eruption was making its appearance. In all, however, great swelling of the throat and extensive membranous exudation were early symptoms. Three other cases of the same

kind having occurred, and isolation being impracticable, Dr. Michie was led to abandon curative for prophylactic treatment. There was immediate relief. The membranous exudation began to exfoliate; and in twenty-four hours the process was complete, and the dusky skin gave place to an extremely abundant scarlet eruption. All three recovered. A few less severe cases occurred in houses where the disease had already existed in the malignant type, and where the vapor treatment had already been instituted. These were followed by several cases of a progressively milder type, and finally the outbreak was quelled, after having invaded nine houses and affected thirty children, of whom five died. From the above description there could not be the least doubt of the value of the treatment. As an illustration, Dr. Michie cited that of a house of two apartments, three beds and ten inhabitants, in which two of the fatal cases occurred. These two children were treated in a room where four other children slept, where the food for the household was cooked, and where the family congregated during the illness of the two children. The vapor-treatment was commenced in this house only an hour or two before the death of the second child, and was energetically continued for some days, when four of the family suffered, not from scarlet fever, but from a "catarrhal pharyngitis." or "scarlatina sine eruptione." No one else in the household suffered. Another case was that of a boy aged eight, who suffered from the anginous variety, with rash on second day, and who occupied one of three beds in a room measuring 13x14 feet, in which seven other persons, including three adults, slept. Here the vapor-treatment was early adopted; the boy made a good recovery, and no other member of the household suffered even from sore throat. Dr. Michie was of opinion that the quality of the carbolic acid had a good deal to do with the success of the treatment. It had a heavy, black, tarry appearance, as if so much coal-tar oil had been carried over in the process of distillation. Half an ounce of this was vaporized every three or four hours by placing it on a flat piece of heated iron. In this way a vapor of great density and volume was produced, which penetrated into the utmost recesses of the sick-chamber, and into the clothes and respiratory tracts of the occupants. Dr. Michie thought the success depended (1) on getting the full antiseptic value of the acid in a state of vapor; (2) on the quality used, partly tar, partly acid; (3) on the frequency with which it was applied; and (4) on the continuance of the treatment for days after the last case in a house had recovered. The more malignant the type, the more value was to be derived from the early application of

the tar and acid in a state of vapor; and, whatever the type, the sooner the disinfectant treatment was brought into use, the sooner they would be able to eradicate the outbreak of so infectious a disease.

CASCARA CORDIAL AS A VEHICLE AND CORRIGENT.—In a paper read before the Medical and Surgical Society of the Kanawha Valley (*Med. and Surg. Reporter*), Dr. R. S. Henry, of Charleston, W. Va., says: "While much may be done by the proper selection of the concentrated and improved forms of medicine, and by administering nauseous drugs in pills and granules or capsules, there still remain many drugs which it is necessary or expedient to administer in fluid form. It is to render this large class of preparations acceptable to the palate that the physician often tries the whole line of vehicles without satisfaction to himself or to his patient. A vehicle which would combine the properties of compatibility, permanency, and innocuousness, and above all possess the quality of disguising and rendering positively agreeable to the taste many of these nauseating and bitter preparations, must necessarily meet with the universal appreciation of practitioners, and be a priceless boon to their patients. It is the purpose of this note to call attention to such a vehicle and corrigent, and to suggest a few illustrative formulæ which will indicate its very wide range of application in every-day practice. We believe that that combination of aromatics and carminatives with *Cascada sagrada*, known as cascara cordial, introduced by Parke, Davis & Co., fulfills every required indication. In addition to its power of disguising the taste of such bitter medicines as quinine, its gentle laxative properties render it peculiarly well adapted for addition as a corrigent to the many preparations which, given alone for any length of time, tend to interfere with the normal action of the bowels, such as the various preparations of iron and opium, than which no others are more frequently indicated and more used by physicians."

[We have used the cordial in this way for some months, and with very great satisfaction.—J. F. B.]

MANY instances can be found in which the medicine prescribed by the physician has been changed for a cheaper substitute by non-reliable druggists, among which we have seen mentioned one in which thirty grains of quinine produced no signs of cinchonization, but the same doses in Warner's pills produced marked evidences of it. Another in which four ounces of a mixture of bromide of potassium and chloral, with tincture of hyoscyamus and fluid extract of cannabis Indica, in

SELECTIONS.

... were ordered, which only caused nausea, with no soporific
... a similar prescription, in which "Battle's Bromidia"
... produced the desired result.—*Weekly Med. Review.*

THE TREATMENT OF EPILEPSY.—Dr. E. D. Fisher, of
... the treatment of epilepsy upon the bromides ex-
... as a rule the mixed bromides, giving four parts of
... bromide to two parts each of the sodium and ammonium
... cardiac weakness is present he gives digitalis or
... ammonia. When anemia is present he never finds
... His experience convinces him that the use of brom-
... even for years, does not cause mental disturbance, but
... controlling of the disease leads to the improvement of the
... This accords with English experience as recorded by Dr.
... —*Amer. Jour. of Nerv. and Mental Dis.*

SUCCESSFUL TREATMENT OF SCIATICA.—Dr. John T. Metcalfe
... following prescription, which he has used with marked success

Tinct. aconit. rad.,
Tinct. colchici sem.,
Tinct. belladon. : equal parts. M.

—Six drops every six hours until relieved.

He uses tablet-triturates, each of which contains three drops of the
... mixture as the most convenient form in which to prescribe its
... ingredients:

Tinct. aconit rad.,
Tinct. colchi sem.,
Tinct. belladonæ,
Tinct. actæ racemosæ ; equal parts by volume.

One of these tablets is given every four, six or eight hours, as may
... be needed.

Marked beneficial effects have followed its use in three days ; and in
... neuralgia of the axillary and brachial nerves it has proved of great value.
—*Boston Med. and Surg. Jour.*

A LONDON physician, who for six months tested Dr. Jaeger's plan of
... wearing nothing but wool, day or night, says the result has been a com-
... plete immunity from colds and a marked increase in capacity for work.
... Instead of alternate feelings of heat and cold, there has been a uniform
... and most agreeable glow of warmth.—*Australian Journal of Pharmacy.*

PNEUMONIA, TREATMENT OF IN BELLEVUE HOSPITAL.—Immediately upon admission every patient under the charge of Prof. Loomis undergoes an examination for the determination of the following points: 1. The extent and location of pulmonary consolidation and amount of complicating pleurisy. 2. The temperature and condition of the heart as indicated by its rhythm, force, and amount of muscular element in the first sound. 3. The condition of the kidneys.

When the patient is admitted during the initial shock, full doses of morphia are administered hypodermically, and repeated with sufficient frequency to relieve pain, during the first three or four days, or until the consolidation is complete. Every patient is placed in bed, clothed in an oil-silk, flannel-lined jacket, which is made to come close up around the neck and to extend well down onto the trunk, and is put upon a diet of milk, chicken-soup, and beef-tea, the selection of food being somewhat affected by the limits of hospital dietary. This much is routine.

When consolidation is confined to a lower lobe, the cough, expectoration, and pain moderate, the temperature below 104° F., while the pulse is regular with a strong first sound of the heart, and the urine is normal, nothing further is done beyond keeping the bowels freely open by some mild cathartic, as pulv. glyc. co. The general treatment is then purely expectant. The temperature and pulse, however, are taken every four hours and the urine examined daily.

When the temperature reaches 104° F., or more, fifteen to twenty grains of quinine are given at a single dose. If at the end of six hours no reduction of temperature is produced, twenty grains are given in divided doses within an hour. As the drug used is "hospital quinine," these doses are possibly slightly larger than would be required in general practice. When they fail to reduce temperature equal parts of quinine and antipyrin are employed, but always in combination with some form of cardiac stimulant, as alcohol or caffeine. If the temperature is not affected by the second dose its use is not continued.

Indications for stimulants are found principally in the cardiac condition. Patients with consolidation at the apex, however, and alcoholic subjects are put upon stimulants from the first. The cardiac stimulants used are alcohol, caffeine, digitalis, and ammonia, the first two being given with about equal frequency and for prolonged effect, while the others are used more for emergencies in the later stages. An irregular, uneven, intermittent pulse, or weak or absent first sound are indications for stimulants to be given as needed.

It is seldom found necessary to employ measures directed especially to the cough. When this is distressing, with little expectoration in the earlier stages, opium is employed to mitigate its severity but not to check it entirely; later, in the stage of resolution, opium is avoided and carbonate of ammonia given in connection with infusion of serpentaria or wild cherry.

Pain is controlled early by opium and *large hot* poultices, later by poultices alone, if possible.

The earliest indications of renal complications are met by the ethers, infusion of digitalis, and nitroglycerine.

Sleeplessness is relieved by bromide and chloral (alone in robust patients), and with the addition of cardiac stimulants in alcoholic subjects.

Edema is treated by dry cups freely applied over the entire chest, atropia hypodermically, whiskey and digitalis internally, and the free inhalation of oxygen.—*Med. News.*

A FORMULA by Germain See for the relief of the pain after taking food, in patients with cancer of the stomach, is as follows:

R. Tinct. conii,
Tinct. hyoscyami,
Ol. anisi. aa ʒij.
Tinct. gentianæ ʒj.

S.—Ten to thirty drops after meals.—*Weekly Med. Review.*

MORPHEOMANIA may always be treated by abrupt withdrawal of the drug, except in conditions when such methods are contra-indicated by the vital forces of the patient, or concomitant pathological phenomena. The method should also be abandoned if reactionary collapse result.—*Jour. of Inebriety.*

A PRESCRIPTION FOR ACUTE BRONCHITIS.—Muirhead, (*Edin. Med. Jour.*) gives the following as serviceable in the preexudative period of acute bronchitis:

R. Vini antimon. ʒiij.
Liq. potassæ. ʒij.
Liq. ammon. acet. ʒiij.
Syr. aurant. ʒjss.
Aquam ad. ʒvj. M.

Sig.—One tablespoonful in a wineglassful of water every three hours.

Académie de Médecine } tions throughout Europe, and by the entire Medical } years.
of France. } Profession, since 1863.

VIN MARIANI

(ERYTHROXYLON COCA.)

THE MOST EFFICACIOUS AND AGREEABLE OF TONICS AND STIMULANTS, AND WITHOUT ANY UNPLEASANT REACTION.

FORMULA.—VIN MARIANI is the concentrated extractive of the fresh leaf of ERYTHROXYLON COCA and an excellent special quality of Bordeaux Wine, each wine-glassful containing the medicinal properties of thirty grains of the fresh *selected* leaves.

DOSE.—Usual dose is one wine-glassful about half an hour before or *immediately after* each meal; for children, half the quantity.

FOR twenty-five years "**VIN MARIANI COCA**" has been introduced exclusively to the **Medical Profession**, and has invariably given them uniformly good results in their practice. As a strengthener of the nervous system, with especial good effect on the respiratory and digestive organs, it is pronounced superior to any other adjuvant. Owing to the large demand for Vin Mariani, imitations and substitutions are being forced on patients where physicians do not especially specify

→ "VIN MARIANI," ←

and we would respectfully call attention to this fact, as being the cause of failure to secure good effects in many cases where Coca is prescribed.

TREATISE, 53 pages (translated from the French), will be sent **gratuitously and post-paid to any Physician mentioning this Journal.**

Price for Vin Mariani is reduced; and where druggists do not keep it, we will supply it to patients by the case of twelve bottles for twelve dollars. Remittance in all cases must be sent with the order.

To physicians, for their own use, a discount will be made.

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11 Boulevard Haussmann.

127 FIFTH AVENUE,
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Correspondence from Physicians solicited.



Combinations for HORSFORD'S ACID PHOSPHATE.

As the "Acid Phosphate" of Prof. Horsford is more extensively used, one of its characteristic qualities, that of an adjuvant, becomes better known and appreciated. The experience of physicians of the various schools shows that it combines readily and very effectively with a great variety of other remedial agents. It is a superior substitute for the official Phos. Acid. Dil., as it acts more effectively, and does not produce the irritation sometimes noticed upon the exhibition of that remedy.

Below we give a series of prescriptions in combination with Horsford's Acid Phosphate, and believe them worthy the careful consideration of medical practitioners. These prescriptions are the result of careful study, and they serve to show the wide usefulness of Prof. Horsford's excellent preparation.

* These combinations are largely used by the profession.

*Acid Phosphate with Strychnia.

R
Horsford's Acid Phosphate $f\frac{3}{4}$ viij
Strychninæ Sulph $gr. j$
M

Sig: Half to one teaspoonful in a glass of water.

Acid Phosphate with Quinine.

R
Horsford's Acid Phosphate $f\frac{3}{4}$ ss
Quininæ Su'ph. $gr. xvj$
Syrupi Simplicis $f\frac{3}{4}$ ij
Aquæ $f\frac{3}{4}$ ss
M.

Sig: A tablespoonful in a wine glass of water.

Acid Phosphate with Emulsion of Cod Liver Oil.

R
Emulsion Olei Morrhuæ 50% $f\frac{3}{4}$ vij
Horsford's Acid Phosphate $f\frac{3}{4}$ j
M.

Sig: A tablespoonful.

*Acid Phosphate with Wine of Pepsin

R
Vini Pepsinæ $f\frac{3}{4}$ vj
Horsford's Acid Phosphate $f\frac{3}{4}$ ij
M.

Sig: A dessertspoonful in water.

Acid Phosphate with Elixir of Iron and Quinine.

R
Elix. Ferri et Quininæ
Horsford's Acid Phosphate $aa f\frac{3}{4}$ iij
M.

Sig: A teaspoonful in water.

*Acid Phosphate with Tincture Nux Vomica and Compound Tinc- ture of Gentian.

R
Horsford's Acid Phosphate $f\frac{3}{4}$ vj
Tinct. Nucis Vom. $f\frac{3}{4}$ j
Tinct. Gentianæ Comp. $f\frac{3}{4}$ ij
Syrupi Simplicis $f\frac{3}{4}$ iij
M.

Sig: A tablespoonful in water.

We do not prepare the Acid Phosphate in any of the above combinations.

Physicians who have not used Horsford's Acid Phosphate, and who wish to test it, will be furnished a sample on application, without expense, except express charges on application to

RUMFORD CHEMICAL WORKS,

Providence, R. I.

OBSTETRICS.

THE TREATMENT OF BRONCHIAL CATARRH IN CHILDREN.—Dr. James Carmichael, of Edinburg (*Edin. Med. Jour.*), gives a sketch of the clinical features and complications of bronchial catarrh in children, with its general management and treatment, from which, at this season of the year, a few of the more important points may be extracted with profit.

In this class of diseases in children the administration of drugs is of secondary importance to the details of hygienic and dietetic management; and as in the treatment of disease in children generally, more success in practice is derived from little details than anything else. All our efforts as physicians should be directed to warding off the complications likely to arise as a secondary result of bronchial catarrh, namely, pulmonary collapse with its compensatory emphysema, and catarrhal pneumonia. The end we desire to attain in a case of acquired atelectasis is, if possible, reinflation of the collapsed portion; and there can be little doubt that, in a certain proportion of cases, this can be brought about. In many of the milder cases of bronchial catarrh, the smaller tubes remaining unaffected, when sudden collapse occurs, prompt and energetic measures will suffice to restore the lung to a natural condition. In extensive capillary bronchitis it may be doubted whether complete or partial reinflation ever takes place. The first indication for treatment is to promote and encourage free respiration, more especially the act of inspiration. For this purpose the child's clothing must be light and loose; the abdominal bandage in infants should be removed. The child should be made to lie on the sound side in case of one side only being affected, so as to allow the affected side full play. It should not be allowed to sleep or lie too long, such children often being very drowsy, but should be taken up at intervals and made to cry if possible. The nurse may be instructed to cool her hand by placing it in cold water, and apply it suddenly to the chest, in order to induce a sudden inspiration. The room should be not too hot, and well ventilated. Stimulating epithems may be applied to the chest, such as hartshorn, mustard or turpentine. The child should be fed regularly and very frequently with food suitable to its age. Whatever be the age of the child, it generally requires stimulants; and a few drops of brandy, or in the case of a sucking infant, sack whey should be given. The most serviceable medicines are those of a stimulating nature, such as sal volatile, or subcarbonate of ammonium, which should be given in small doses, frequently repeated. . Belladonna is undoubtedly of use in

those cases of collapse occurring suddenly in slight catarrh in comparatively healthy children, more especially where we have reason to believe there is temporary occlusion of the tubes from nervous, spasmodic or reflex causes. The drug should be given in full doses, and repeated with sufficient frequency to insure a sedative effect. In acute bronchial catarrh, one of the best means of moistening the air is to keep a clothes screen around the child and cover it with a wet sheet. Very rapid evaporation takes place; so that the sheet, provided, the temperature of the room be kept high enough, requires to be re-dipped every hour or hour and a half. Or a flat sponge bath, with about an inch deep of water in it, may be kept in the center of the room or near the bed; or we may hang wet towels all around the inside of the cot upon a cord suspended for the purpose. By this means the air of the cot is kept quite as moist as by means of the steam kettle, which Dr. Carmichael now seldom uses in hospital except in croup cases. Acute bronchial catarrh in children is generally relieved by rubefaction of the chest and local diaphoresis, produced by the application of sinapisms; but care must be taken not to continue these too long. The chest should then be encased in a light cotton-wool jacket, which serves the purpose of keeping up a uniform temperature on the surface, and answers admirably. The jacket may be basted on a fine cotton or linen jacket; or, if the skin do not act sufficiently, on to a thin macintosh cloth jacket; or the jacket, instead of being applied dry, may be squeezed out of water before application, in which case we have a clean and light poultice which can be worn continuously. A very convenient and ready method of medicating the cotton is to sprinkle over the jacket, before it is applied, a few drops of eucalyptus, pinewood oil or terebene. Whichever method is adopted, these applications are in the case of children more suitable and convenient in every way than the old emollient poultices. With respect to drugs in acute bronchial catarrh and its complications, the routine treatment too often in vogue of giving ipecacuanha or squill cough mixtures, with the indiscriminate application of poultices, cannot be too strongly deprecated. Every case should be treated strictly on its own merits, and with regard to the constitutional peculiarities of the child. Whilst ordinary cases of mild bronchial catarrh may be treated without the administration of any medicine except an aperient, or it may be an emetic, great benefit is derived from carefully selected therapeutic measures in severe cases. The indications for the use of emetics are constant dry cough with deficiency or dryness of the secretion, high fever with full strong pulse, and deficient

action of the skin. An emetic of apomorphine or sulphate of zinc, with or without ipecacuanha, or of ipecacuanha alone, seldom fails to give relief to the symptoms, by promoting the secretion of both bronchial mucous membrane and skin; but care must be taken in the administration of this class of remedies. Judicious selection of expectorant remedies is necessary according to the exigencies of the case. Whilst in strong children during the earlier stages of severe bronchial catarrh great relief is obtained from the use of the sedative circulatory expectorants, such as antimony, apomorphine or ipecacuanha, with or without alkalies, it must be remembered that children do not bear the administration of this class of remedies as well as adults, or at all events do not stand a long continuance of their administration so well. Perhaps the most useful of all the expectorants in children are the saline—the alkaline carbonates, or the citrate of potassium, combined with minute doses of the sodium or ammonium iodide. Terebene seems specially useful in cases where there is deficient secretion associated with bronchial muscular spasm. Two or three drops given along with the child's food often give great relief to the cough, and otherwise allay irritation. In acute catarrhal pneumonia the main indication is to support the patient's strength by suitable diet, and stimulants if need be. Antipyretics are often required. The class of ordinary expectorants is usually contraindicated, except those of a stimulating nature. Most reliance must be placed on tonic doses of quinine or nux vomica after the first week or ten days.—*The Practitioner*.

TERMINATION AND TREATMENT OF EXTRAUTERINE PREGNANCY.—Maygrier, in a recent thesis, writes as follows on this subject: Whatever be the anatomical peculiarities of a case of extrauterine pregnancy it must terminate in the rupture or retention of the fetal cyst. Rupture, which is exceptional in abdominal pregnancies, is the rule in tubal pregnancies, and often occurs at the second or fourth month. Occurring abruptly, it produces death by hemorrhage, peritonitis, strangulation, or septicemia. Recovery can occur when the rupture occurs during the first weeks; early rupture produces the symptoms of periuterine hematocoele, and the diagnosis cannot be made positively without an exploratory incision.

In exceptional cases recovery may occur in cases further advanced, the fetus dying and undergoing absorption, or living until viable. A retained fetus may become encysted as a foreign body, and undergo calcareous degeneration; this degeneration presents great varieties.

It is well, with Barnes, to advise patients in whom encystment has resulted favorably to avoid subsequent pregnancies, as the retained cyst may become the occasion of dangerous accidents; when new pregnancies occur they may give rise to inflammation and suppuration in the cyst, and peritonitis follow.

Spontaneous evacuation of ruptured cysts occurs through the intestines, the abdominal wall, the vagina, and the bladder.

Treatment varies with the stage of fetal development.

In early months, before the rupture of the cyst, it should be removed by laparotomy; the fetus may sometimes be removed per vaginam.

When the cyst ruptures immediate gastrotomy is the only treatment; in Lawson Tait's hands 21 of 21 patients so treated recovered.

In the last months of pregnancy, when the child lives, laparotomy will save the mother from the dangers which threaten; when the child is dead, the expectant plan should be followed, and laparotomy done only as dangers arise which necessitate it.

When the fetal cyst is only partially opened, the intervention must vary with the case.

In summing up, the author considers laparotomy indicated in the first months of extrauterine pregnancy, and at the rupture of the sac; in the later months of pregnancy, when the child lives (with special care against placental hemorrhage), and when the child has been dead for some time.

Elytrotomy is preferred when the fetus is fixed in the pelvis, when the placenta is not lying between the cyst and the vaginal wall.—*Revue de Chirurgie. Med. News.*

THE VARIOUS SUBSTANCES RESEMBLING MEMBRANES FOUND IN THE THROATS OF CHILDREN.—According to the famous pediatrician, J. Simon, these products are as follows:

1. Diphtheritic products embedded in the mucous membrane and firmly attached to it by fibrous prolongations. The fibrous nature of this membrane may be demonstrated microscopically. These exudations are usually accompanied by enlargement of the submaxillary glands and slight rise of temperature.

2. Pultaceous products, that is, epithelial substances with mucus.

3. Herpetic products, often found in connection with tonsillitis. These are all soluble in water.

4. Products arising from cauterization.

PRURITUS PUDENDI.—Parvin, in eczematous inflammation, recommends poultices and alkaline washes, followed by a powder of starch and oxide of zinc, or the subnitrate of bismuth, or an ointment of white precipitate. Constitutional treatment, a milk diet, and the use of Fowler's solution will be beneficial in most cases.

In ordinary pruritus hydrocyanic acid is one of the best applications to relieve the itching. Levrat recommends the following formula :

R. Plumbi acetatis.....gr. xv.
 Acid hydrocyanici dilut.....3 ss.
 Aqua.....3 v. M.

If excoriations exist, the following may be applied :

R. Balsami Peruviani.....3 ss.
 Ol. amygd. dulc.....gr. xlv.
 Acaciæ.....3 i.
 Aquæ rosæ.....3ss. M.

If the disease be parasitic in origin, a mixture of equal parts of sulphurous acid and glycerin may be applied, or a sulphur bath taken. Finally a six to ten per cent. solution of cocaine muriate may be brushed over the irritated surface. Hot applications are sometimes very effective ; others find more relief in icewater compresses.—*College and Clinical Record.*

A READY METHOD OF INDUCING RESPIRATION IN INFANTS BORN ASPHYXIATED.—(Enos T. Blackwell, M. D., in *Med. and Surg. Rep.*)—In the resuscitation of asphyxiated infants newly born, I have long used a procedure embodying the principles of the Marshall Hall method, viz., by tossing the child with a quick motion, the placenta being still attached. The rapid movement causes the arms to fly up, lifting the chest-walls, and causing the infant to take in air by a sudden sob. The method may appear rude, but it has succeeded in many instances apparently desperate. It has the merit of instant applicability, with very quick results ; and experience with it induces me to believe it unfailing in the recovery of newly-born infants perishing from asphyxia. In the procedure, the head, neck and shoulders are supported in the palm of one hand, while the buttocks rest in that of the other. A few tosses are generally sufficient to elicit a cry. As a part of the literature of a subject that must interest the great body of medical practitioners, and which is strangely neglected in some systematic works on midwifery, I recall the attention of the profession to a plan which I believe has special merit.

THE ANTISEPTIC TREATMENT OF SUMMER DIARRHEA.—Dr. L. Emmet Holt thus concludes a paper in the *N. Y. Med. Jour.* :

1. Summer diarrhea is not to be regarded as a disease depending upon a single morbid agent.

2. The remote causes are many, and include heat, mode of feeding, surroundings, dentition, and many other factors.

3. The immediate cause is the putrefactive changes which take place in the stomach and bowels in food not digested, which changes are often begun outside the body.

4. These products may act as systemic poisons, or the particles may cause local irritation and inflammation of the intestine.

5. The diarrheal discharges, *at the outset*, at least, are to be looked upon as salutary.

6. The routine use of opium and astringents in these cases is not only useless, but, in the beginning particularly, they may do positive harm, since, by checking peristalsis, opium stops elimination and increases decomposition.

7. I do not deny or undervalue opium in many other forms of diarrhea than the one under discussion.

8. Evacuants are to be considered an essential part of the antiseptic treatment.

9. Experience thus far leads me to regard naphthalin and the salts of salicylic acid as the most valuable antiseptics for the intestinal tract.

ERGOT IN LABOR AND PUERPERAL CONVALESCENCE.—Prof. Thad. A. Reamy thus concludes a valuable paper on this subject (*Lancet and Clinic*):

1. Ergot may properly be administered in small doses, say ten to twenty drops of Squibb's fluid extract, before delivery in cases of uterine inertia which resists other means, and especially in women who are predisposed to hemorrhage.

2. It should be administered in full doses hypodermatically, or per os, or both, in cases of post-partum hemorrhage.

3. When an anesthetic has been freely used during the second stage of labor, it to some degree predisposes to post-partum hemorrhage; ergot is therefore indicated.

4. It should be administered in small doses two or three times daily during the period of puerperal convalescence, whenever a flabby uterus indicates it. In such cases there is no better combination than the pill recommended by Munde:

Ext. Ergot.....	1 gr.
Quinine.....	1 gr.
Ext. Nux Vomica.....	$\frac{1}{4}$ gr.

SURGERY.

PARAFFIN IN SURGERY.—It is perhaps not so well known in the profession as it ought to be, that paraffin is a most useful material in surgery, in many cases superseding plaster of Paris. It answers admirably for splints, and for jackets for young children suffering from spinal disease. The advantages of it are that it is clean, light, is capable of being moulded while it is soft, and sets rapidly by pouring cold water on it. It must be procured with a melting point of 130° . When ordering it, it is necessary to specify the melting point required. The mode of using it is this: The paraffin is melted by placing a tin can containing it in a pot of boiling water. A muslin bandage well sprinkled with iodoform is put on the limb, or other part to which the paraffin dressing is to be applied. Muslin bandages loosely rolled are allowed to soak in the paraffin for a few minutes. If much support is required, a piece of cotton-wool is also soaked in the paraffin. This is placed where most stiffness is wanted, and the bandages applied as for plaster of Paris dressing. They may, however, be drawn tight as the paraffin shrinks from the limb in cooling. Cold water is then poured on it, and the limb held in position till the paraffin has set. When a bone tends to project, it can be kept in position by the finger till the paraffin has set. The hole left by the finger can then be filled up with some melted paraffin. In cases of compound fracture, the paraffin has the great advantage of not being affected by the discharge from the wound.

BRAIN SURGERY.—Facts do not appear to favor the prosecution of this branch of the surgical art, and the more they are looked into by the light of results the less do they support the views of the F. R. S., who painted them in such glowing terms recently in a contemporary. Unfortunately for that (his, F. R. S.'s) view, says Dr. Goodhart, in the Pathological Society's Transactions, "I had in my mind another case in which, according to the diagnostic skill of Dr. Ferrier himself, a cerebral tumor was judged to be a fit case for the attempt at its removal. The man died before the attempt was consummated, and the tumor was found to occupy the entire thickness of the anterior third of the affected hemisphere. *This is the way in which (italics ours) most of these cases reject the advances of surgery.* Extensive disease in the white matter gives so little evidence of its presence. For the last thirteen years I have been making post-mortem examinations at Guy's Hospital, and during that time, although I have come across many cases of cerebral tumor, I do not remember to have

seen a single case in which the tumor was at the same time *accessible* and so *localized* as to be capable of successful surgical attack. * * When, therefore, I read that the case to which I have alluded has opened the door to successful treatment of scores of similar cases, I can only say that a consideration of all the facts and particulars of that case makes one very doubtful as to the accuracy of F. R. S.'s judgment. I am the more inclined to take the opposite view, viz., that it is very doubtful whether in the region of cerebral tumors, other than inflammatory, *surgery has any future worth mention before it.*" So speaks an able pathologist, as well as a practicing physician of specialized experience on the point, and we trust that the authorities of our hospitals, surgical and otherwise, will take stock of these statements, and either prohibit entirely or reduce to a minimum these ingenious but withal useless operations. Assuredly, if they do not, some irate friend or relation will interpose and call them or their operator to a severe account. Woe be to him who ignores such teaching and such facts as we have just reproduced! However disinterested he may appear to be, no jury could "find" for him in face of such damning evidence as this of Dr. Goodhart's undoubtedly is. It more than upholds Surgeon-General Gordon's inquiry as to the *cui bono* of such wild surgery or more worthless experimentation. Confirmatory also of this view, we have before us opinions of the Committee on "Morbid Growths or Intra-cranial Tumors," as follows: "The Committee felt that it would be impossible to pass over the question of surgical treatment in intra-cranial growths. Yet out of the fifty-four tabulated cases *two only seemed suitable for removal.* Again, "the fact that intra-cranial growths may exist in certain parts without giving rise to symptoms referable to such parts, their tendency to compress and displace without destroying, and lastly, the pressure they exert on remote parts *very often render their localization a matter of pure conjecture.*" Verily Dr. Gordon may again repeat his *cui bono*, without any expectation of getting it satisfactorily answered, and if these several statements are—as they undoubtedly are—true, then might Ferrier as well have been beating the air as boring holes into the crania of monkeys, or cutting slices out of their contents.—*Medical Press.*

REMEDY FOR DANDRUFF, FRECKLES, ETC.—In the *Am. Practitioner and News*, of January 8th, we find an interesting lecture by Dr. McGuire which contains some interesting practical hints of importance to the general practitioner who is constantly beset by his friends in busy office hours, as well as in the enjoyable social circle, to give them a remedy for

dandruff, freckles, bumps on the face and falling hairs, etc. After giving the anatomy and physiology of the skin, the author gives the following practical suggestions: Bromidrosis (offensive sweating) may be relieved by the use of a dusting powder of Salicylic acid ʒss to Starch ʒi. Or a sol. Permang. Potass. one grain to the ounce. The socks should be soaked in this and dried before being worn.

Discolorations, such as liver spots and freckles, should be left alone, since if they are removed by strong stimulating applications, the chances are greatly in favor of their return at an early day.

A lotion of Tinct. Cantharidis ʒss to Bay Rum ʒi is recommended as an excellent remedy for dandruff and premature baldness.

For hives—Urticaria—emetics, and saline cathartics are to be used internally, while vinegar and water, whisky, alkaline baths and lotions of carbolic acid and water are to be used externally.

It is well known that many dye-stuffs may cause inflammations of the skin as well as constitutional poisoning. Colored stockings have been found to contain poisonous quantities of arsenic and antimony. I have seen many cases of eczema produced in this way in persons predisposed to it, not only by colored stockings but by the colored hat bands, glove and shoe-linings, etc. Colored underclothing has done likewise when worn before it was washed. The treatment of this local poisoning is the removal of the cause, and the use of bland applications.

Hair-dyes as a rule are harmful. They may not only cause baldness from the lime, lead, and silver they contain, but the lead may be absorbed and act injuriously on the system.

In summing up his lecture the author refers to the popular fallacy as regards the too rapid curing of a skin disease, they considering that the presence of an eruption is a sure indication of bad blood, and that it is undesirable to "drive it in" too quickly. "In fact the blood has little to do with skin diseases; and while it is true that now and then a patient may get well while using these much puffed nostrums, it is about on a par with the lotteries, where they advertise the fortunate ones who have drawn prizes, while tens of thousands who have not are never heard from.—*Med. Review.*

DISINFECTION OF THE HANDS.—Referring to the fact that after autopsies in certain cases, such as puerperal peritonitis and typhoid fever, the fingers remain impregnated for hours with a fetid odor, of which they cannot be deprived by repeated washing, Duclos states, in the *Revue de Therapeutique*, that this can be instantaneously removed by the use of the

potassic permanganate and the sodic bisulphite. The permanganate may be employed in the proportion of 5 to 1,000, or 5 to 100, and the commercial solution of the bisulphite diluted with five parts of water. The method advised is as follows: First thoroughly wash the hands with soap and water; then in the permanganate solution, the time varying according to its strength, two minutes being sufficient, if the solution be concentrated; the hands are then placed in the solution of the bisulphite, and they become at once white, the discoloration caused by the permanganate instantly disappearing.

Duclos claims that this method not only completely removes the repulsive odor, but also thoroughly disinfects the hands, and that it will prove useful to both surgeons and accoucheurs. So far as the latter class is concerned, they have no business with post-mortem examinations of infectious cases; and doubtless should the plan advised by Duclos be employed by them they ought to add to it the careful and thorough use of the nail-brush, to be followed by dipping the hands in a solution of corrosive sublimate 1 to 1,000.—*Med. News.*

HYPERIDROSIS PEDUM.—In the experience of the editor of the *Journal of Cutaneous and Genito Urinary Diseases* in the treatment of habitual hyperidrosis pedum, the best results have been obtained from the employment of foot baths of a strong solution of extract of pinus canadensis (Kennedy's) every night, and the use of powdered boracic acid, or salicylic acid mixed with lycopodium, oxide of zinc or other inert powders, constantly applied inside the stockings. Hebra's treatment with diachylon ointment undoubtedly constitutes a most efficacious method, but the inconvenience attending its application, often temporarily interfering with the occupation of the patient, renders its employment impracticable in many cases.

CYSTITIS—(Reliquet).—Morning and evening a general bath of tepid water; an hour after, the following suppository should be introduced into the rectum:

R Iodoform.....gr. jss.
Ext. hyoscyami.....gr. j.
Olei theobromæ.....gr. xlv.

—*Les Nouveaux Remèdes.*

ECTROPHY OF BLADDER.—Dr. Neihaus, of Berne, extirpated the bladder, two years ago, in a boy of six years, on account of ectropia. The ureters were drawn forwards and fixed in the epispadic groove on the penis. The patient wears a convenient urinal. He was shown at a recent meeting of the Berne Medico-Pharmaceutical Society.

COLUMBUS MEDICAL JOURNAL.

EDITORIAL.

HEALTH vs. HEATING AND VENTILATION.

The heating and ventilation of our houses has so much to do with the health and comfort of the inmates that it surprises us that it receives so little attention. With the proper appliances used, the vitiated or foul air is removed, and a supply of fresh admitted, but when such precaution is ignored, the germs of disease gain an easy foothold, and scarlet fever, diphtheria, and other kindred maladies assume a malignant type. Parties building would do well to dispense if necessary with some extravagant ornamentation, and supply their homes with a good hot-water heating apparatus, such as that brought out by Mr. Samuel D. Tompkins, engineer, and manufactured by the A. A. Griffing Iron Co., 518 Communipaw ave., Jersey City, N. J., which meets all the conditions required; *i. e.*, cheapness, durability and effectiveness; the latter, however, being the most prominent. On application the A. A. Griffing Iron Co. will send their handsome illustrated circulars, both of hot water heating and ventilating apparatus, and their numerous constructions for steam uses, and those who may be building, or about to build, would do well to consult the above firm before purchasing heating appliances.

Fluid Forms of Hydrastis.

The reputation of this drug as a therapeutic agent was first gained through its employment in the form of an *infusion*; and in the fifty years following its introduction into medical practice, a continuous effort has been made by manufacturers to perfect a preparation which would represent all the active principles of the drug, without the high price of the salts, either alone or in combination.

The most prejudiced writers on *Materia Medica*, accord to the late Wm. S. Merrell the largest share of credit in the introduction of Hydrastis preparations, and to the present organization the reputation of being the *largest consumers of the drug in the world*. For more than a half-century, Hydrastis has been made a study in our laboratory, and we do not think we exaggerate its importance when we assert that it stands pre-eminent to-day as the most valuable exponent of our vegetable *Materia Medica*.

The following preparations in *fluid form* are receiving our special attention at this time:

Fluid Hydrastis—MERRELL.

Is what its name implies—the active, medicinal principles of the drug in natural combination and in a fluid form. It has a bright, yellow color, perfectly clear, free from sediment, and with an unmistakable odor of the *fresh drug*.

Fluid Hydrastis is a pure, neutral solution of all the alkaloidal constituents of the drug, rejecting the oil, gums, irritating and offensive resins and inert extractive matters. The success attending its introduction is the best evidence of its therapeutic value.

Unsuccessful imitations and would-be substitutes are met with on every hand. Preparations said to be “just as good” or “about the same thing,” but always “a little cheaper,” attest the wide-spread and growing popularity of Fluid Hydrastis. All such, compared with the latter as to physical appearance or as representatives of the drug, *are condemned*; dispensed in prescriptions, *they are readily detected*; tested therapeutically, *they are promptly rejected* as unworthy of confidence.

Fluid Hydrastis is applicable to the treatment of all irritable, inflammatory and ulcerative conditions of the mucous tract.

This statement of a well-known medical writer and journalist has become axiomatic:

“No remedy for physician's use has been received with such universal approval.”

Solution Bismuth and Hydrastia—MERRELL.

An invaluable and scientific combination, wherein the beneficial action of the white alkaloid is increased by association with Bismuth. This solution contains $2\frac{1}{2}$ grains of the double Citrate Bismuth and Hydrastia; twenty-five per cent. of which is Hydrastia Citrate.

The cordial reception accorded this preparation marks it as the most valuable combination in the market in which the white alkaloid alone represents the valuable properties of the drug. Used in diseases of the nasal passages, of the eye, of the throat, of the stomach and intestines, of the reproductive organs and bladder it is equally beneficial.

Colorless Solution of Hydrastia—MERRELL.

This is a permanent solution of the white alkaloid, without the addition of any other medicinal agent to modify or increase its action. It is offered without special recommendation to meet the views of an unlimited number of physicians, with whom the color of the Fluid Hydrastis is an objection. This solution contains in one fluid pint the same proportionate strength of white alkaloid as exists in an average quality of crude root.

See notes above on Solution Bismuth and Hydrastia.

“Merrell's Hydrastis Preparations” are for sale by Wholesale Druggists throughout the United States. Please Specify “Wm. S. M. Chem. Co.” in ordering or prescribing.

THE WM. S. MERRELL CHEMICAL CO.

CINCINNATI

ORR, BROWN & PRICE and BRAUN & BRUCK, Columbus, Wholesale Agents

EDITORIAL DEPARTMENT.

J. F. BALDWIN, M. D., Columbus, - - - - EDITOR.

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We have *no authorised Collectors*, except such as carry properly made out bills, *counter-signed by the Publishers*.

HANN & ADAIR, Publishers, Columbus, O.

THE TITLE OF "N. C. S. D."—A man recently appeared before the Rhode Island Legislative Committee to testify as to the benefits of quackery and the need of giving everyone a chance to practice medicine. His name was "Baxter, N. C. S. D.," which letters were found to stand for "Natural Common Sense Doctor." In his opinion diplomas did not amount to a row of pins, as they could be purchased in Philadelphia not long ago for \$5 a bushel. He believed that the law should provide that everybody who practiced medicine should be placed under bonds to do as he agreed, and if a failure to do so occurred, the money should be refunded.* If the doctor agrees, or assumes, to effect a cure, and the patient dies, the doctor should pay back all the money he has received, and pay funeral expenses. All of which seems to show that Mr. Baxter was modest in calling his common-sense natural. It is nearer supernatural. But he was not far out of the way in his estimate of the diplomas at present obtainable.—*N. Y. Med. Record*.

We have one of the same "school" in Columbus; he is an "E. P. C. S. D."—"Eclectic, Progressive, and Common Sense Doctor."

THE SINNETT BILL.—This Bill was killed in the House on March 9. It had passed the Senate by a large majority, but the inferior intelligence of the House yielded to newspaper mendacity.

The newspapers of the entire State were generally opposed to the Bill, but chiefly from ignorance of its provisions. Several, however, fought it from, apparently, pure cussedness. The Ohio State Journal, of this city, was most conspicuous for its opposition. It freely admitted to its columns anonymous communications from the lowest quacks, and when there was a dearth of these, copied similar matter extensively from other papers, while its editorial columns teemed with the most absurd and contradictory statements concerning the nature of the Bill. *At the same time it steadily refused to admit any communication whatever in defense or explanation of the Bill, or even in correction of its own outrageous untruths!* It meant to kill the Bill, by whatever means were necessary, and it suc-

ceeded. A fair sample of its editorial utterances is the following, which appeared on the day when it was known that the Bill would come up for final action :

"It is being represented in the lobby that laws similar to the Sinnett star-chamber bill have been passed in a few other States. A prominent medical exchange calls attention to the fact that in every instance where they have been tested the courts have declared them null and void as class legislation."

Of course *our* readers very well know that no medical journal ever made any such statement, and that the statement itself is diametrically contrary to the truth : but the readers of the State Journal supposed it was all true, and *no denial was allowed to appear*. We have given but a single quotation, but similar untruths and half-truths appeared for weeks in nearly every issue of this and other papers.

Several of the members made the point that the Governor had made so many unfortunate appointments on other Boards that they would not create a new one for him to fill.

The undiplomaed doctors were vigorous in their opposition. *One of these was himself a member of the House!*

Finally, such of the medical colleges as are apparently unwilling to have their work reviewed by an independent Board, made an effective still-hunt against the Bill.

THE COLUMBUS RECORD, which, to its honor be it spoken, has uniformly refused to admit any advertisements of patent medicines or quack doctors, was strong in its advocacy of the Bill, as was also a German paper, the *Westbote*. But the Record was a weekly, and not political in character, and so had no 'fluence with the Legislature.

THE two local medical colleges held their commencement exercises as usual. Our reporter was unable to attend either, but we understand that everything passed off after the regulation manner.

Starling graduated 21, out of a class of 93.

Columbus graduated 18, out of a class of about 50.

FRIENDS of the Sinnett Bill were not a little surprised and chagrined to find newspapers, which they had befriended for years, turning against them, and resorting to all the devices of misrepresentation and abuse to defeat the measure. So-called "journalism" seems to have reached a pretty low ebb in Ohio. People in general have a high sense of the right of both sides to be heard, and like to see fair play ; and no little indignation has been expressed, by members of the laity in this city, at the con-

temptible littleness of some of the newspaper managers. Had the papers announced their intention to publish nothing from the other side, there would have been less ground for complaint; but this was carefully concealed, and the impression was conveyed that the Bill had no friends, at least among respectable physicians.

DR. C. O. DUNLAP, of McArthur, has just been appointed one of the resident physicians of the Athens Insane Asylum.

DR. G. W. BOERSTLER, of Lancaster, has removed to Omaha, Neb.

DR. A. B. FRAME, of Athens, has sold out there to Dr. G. W. Blakely, formerly of Guysville, Ohio.

DR. R. HARVEY RRED, of Mansfield, has reported an interesting series of cases of ptomaine poisoning from the eating of dried beef.

MIAMI MEDICAL COLLEGE graduated 29.

OHIO MEDICAL COLLEGE graduated 71.

THE AMERICAN SYSTEM OF GYNEOLOGY, which for some time past has figured among the more important announcements of Messrs. Lea Brothers & Co., of Philadelphia, we are glad to learn is well through the press, and may be expected shortly.

Numbering among its contributors such prominent authorities as Professors Barker, Battey, Engelmann, Garrigues, Goodell, Reeves, Jackson, Lusk, Munde, Reamy, Thomas, Van de Warker, etc., it will certainly present a thoroughly satisfactory and complete statement of the science in its most recent aspects, and we feel justified in congratulating the profession that what has been peculiarly an American specialty is about to receive from American hands the literary tribute due to it.

THE *Indiana Med. Jour.* in an editorial entitled the "City Doctor," says:

"The country physician aspiring to city life may join with some of his brethren who know the ropes, rent, charter, elect trustees, issue catalogue, organize and lecture and be known as 'professor.' Rooms, \$200; outfit, \$100; diploma stone, \$100; permanent endowment fund for catalogue and graduating expenses, \$100. Ten students, if they pay, will be enough to foot the bill. It is not by any means necessary to have so many students as professors, and a board of trustees from the out towns may be had for the asking."

The same in Ohio. We now have sixteen medical colleges, and more in view.

THE City Board of Health is very rigid in its regulations, and during the past month a few physicians were arraigned before the Police Court for neglecting to give proper notification of cases of diphtheria which they were treating.

THE celebrated gynecologist, Professor Schoeder, recently died in Berlin, aged fifty years.

THE appropriation for the International Medical Congress has been reduced by Congress from \$50,000, the sum asked for, to \$10,000. It is provided that the amount appropriated is to be expended under such regulations as the Secretary of the Treasury may prescribe, that no part of the appropriation shall go toward paying the personal expenses of any delegate, and that no money shall be expended except upon vouchers to be approved by the Secretary of the Interior.

ABSORBENT WOOL.—Among the late surgical specialties which have been placed upon the market, is absorbent wool. It is a by-product in the manufacture of lanolin or wool-fat. As all the fatty matters are extracted from the wool we have remaining a substance which is quite markedly hygroscopic. It bids fair to become popular in surgical practice from the fact that it also possesses another advantage, not possessed by absorbent cotton, that it is highly elastic and will not pack. On this account it is much better adapted to apply over points where pressure is to be relieved. It also has the power of absorbing a greater quantity of liquid.

DR. H. C. WOOD, of Philadelphia, has been tendered the chair of medicine at the Johns Hopkins University, Baltimore.

DIED.—Suddenly, at his home in Kansas City, January 11, 1887, A. G. Miner, M. D., Class of '81, C. M. C., age 30 years.

DR. J. W. RUSSELL, of Mt. Vernon, one of the most widely known and ablest of Ohio surgeons, died March 22, aged 83 years.

DR. J. B. POTTER, of Canal Winchester, Ohio, died March 27.

DR. JOSEPH HELMICK, of Harrisburg, O., died suddenly March 30.

REVIEWS AND BOOK NOTICES.

Oxygen in Therapeutics. A treatise explaining the Apparatus, the Material and the Processes used in the Preparation of Oxygen and other Gases with which it may be Combined; also, its Administration and Effects. Illustrated by Clinical Experience of the Author and Others. By C. E. Ehinger, M. D. 12 mo., pp. 158. \$1.00. Chicago, W. A. Chatterton & Co., 1887.

This is the somewhat verbose title of the first work of any pretensions on the subject of therapeutic oxygen, which has yet been issued by an American publisher. The literature of the subject is very meager, American authorities thus far having confined themselves to a few paper reprints from the current medical journals.

Dr. Ehinger disclaims any attempt at originality, but proceeds to give a very fair and creditable, though by no means complete, resume of what has been done and is being done in medicine with oxygen, nitrogen monoxide and various modifications of these gases. We have read the volume with considerable interest, since the subject has all along been associated with a good deal of popular quackery, which has doubtless prevented a majority of practitioners from attempting its use. The author does not assume to have had any experience with the remedy, hence the work is largely made up of quotations from text-books and fugitive writers in the medical press of Europe and America.

Some scientific inaccuracies are noticeable. In giving directions for the preparation of *nitrogen monoxide*, the author says "ammonium nitrate fuses at about 226° F. and decomposes into nitrogen monoxide and water at 329° F.," whereas the salt fuses only at the latter degree of heat, and decomposition occurs at 365° F. Some further assertions concerning the technique of treatment are quite as inaccurate as the above, but on the whole the work is practical and candid. To those who desire to know more of these interesting agents, it will serve as a suggestive guide and at the same time as an active stimulus to more thorough and methodic investigation.

Diseases of the Blood and Nutrition, and Infectious Diseases; being Vol. IV. of "A Handbook of Practical Medicine," by Dr. Hermann Eichhorst, and Vol. XII. of Wood's Library for 1886 (completing the set, price of set, \$15.00.) Illustrated. New York, William Wood & Company.

This is the last volume of Dr. Eichhorst's excellent work on Practice. It consists of three sections; Diseases of the Blood and Blood Producing

Organs; Diseases of Nutrition; and Infectious Diseases. Under the latter head he discusses Tuberculosis and Syphilis. Concerning the former he says: "Tuberculosis includes all the changes ascribable to the presence of the tubercle bacillus discovered by Koch." He thinks it a contagious disease. Although Syphilis is not usually treated of in works on practice, the author gives a very concise resume of that subject.

A Text-Book on Surgery: General, Operative and Mechanical. By John A. Wyeth, M. D., Professor of Surgery in the New York Polyclinic; Surgeon to Mount Sinai Hospital, etc. New York, D. Appleton & Co., 1887. Cloth \$7, leather \$8, half-morocco \$8.50.

This work consists of seven hundred and sixty-nine pages, and contains seven hundred and seventy-one illustrations, of which about fifty are colored. It is printed in clear type on a superior quality of paper, and the book though large is in a shape to be easily handled. The illustrations are prepared with especial reference to accurate anatomy. The relations of bones, muscles, nerves and vessels to adjacent structures are clearly shown, as well as the lines of incision in operations about the joints. The colored illustrations are introduced to depict the more important operations, especially with reference to the large arteries, and they constitute a novel and very important feature of the work: in each of them the vessels and nerves are displayed as in a dissection of the part to be operated on, while by a unique process of shading in the drawing the continuations of the vessels beyond the field of the operation are clearly and beautifully shown.

The author believes in antiseptics, and as a preliminary to the consideration of the various operations he thoroughly discusses the methods of preparing the different antiseptic surgical dressings, ligatures, sutures, solutions and drains.

Amputations, with full and minute details for performing them, and the different methods, constitute an important chapter in the book, all the principal operations being illustrated by engravings (colored) of frozen sections of the cadaver.

Surgical diseases and surgery of the bones and articulations, regional surgery (including the eye and ear), laryngotomy, tracheotomy and esophagotomy, nephrotomy and nephrectomy, laryngeal intubation, the surgery of the thorax and abdomen, and operations on the rectum and anus are presented from the standpoint of advanced surgical knowledge.

This work, written by an accomplished surgeon of wide experience and high attainments in surgical science, is not only beautiful and unique in design and execution, but is also one of the most complete which we have ever seen.

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No. 11

COMMUNICATIONS.

LARYNGEAL STENOSIS—TRACHEOTOMY—SUDDEN RECOVERY OF THE VOICE.

BY C. R. VANDERBURG, M. D., COLUMBUS, O.

Read before the Central Ohio Medical Society, April 7, 1887.

Mr. M., aged twenty-one, a painter, consulted me October 13, 1886. His parents had always been healthy. He himself had always been what would be termed an unhealthy child. The father expressed it rather tersely by saying that he "had spent enough money on his boy for doctor's fees to buy him a farm." He had had chorea. He has no brothers or sisters living; one brother died young, of diphtheria. An opacity of the cornea exists in the left eye. No specific history could be gained. When he came to me he had ulceration of the soft palate and roof of mouth. He had been treated by several physicians for perhaps a month previous, without, he claims, much benefit. Upon examination I found large ulcers of the palate, which had already eaten away the uvula and extended well into the soft palate. Ulceration of the tonsils was also in progress. In the roof of the mouth there was a large and angry point of ulceration, from which necrosed portions of bone afterward came away. A laryngoscopic examination, which was made with great difficulty owing to the irritable condition of the parts and nervous condition of the pa-

tient, revealed nothing of importance, although the voice was husky in tone. The lungs seemed normal; nasal catarrh was present in an aggravated form. The diagnosis made was that the trouble was of a specific nature, and he was placed at once on the mixed treatment, iodide of potassium internally, in doses of about twenty-five grains daily, and mercuric inunctions. The ulcers were cauterized with the solid nitrate of silver, two applications being given a week.

In the course of a month the ulcers had entirely healed, and I lost sight of him; he stopped taking medicine and went to work at his trade.

I saw no more of him until the 2d of January, when he came to me complaining of sore throat and pain in the right side of chest. Thinking it was probably the result of an ordinary cold I prescribed accordingly, with the result that the pain in the chest ceased, but that the throat trouble grew worse. Dyspnea set in, and the voice was greatly impaired. Endeavoring to get a laryngoscopic examination I again failed, owing to the thick tongue and nervous condition of the patient. I applied a swab with a solution of sulphate of copper to larynx. I saw no more of him for several days, but on the 9th of January saw him again with the throat trouble in a worse form than ever. He was suffering from pain in region of larynx. Thinking it was the old trouble farther down, although there was no sign of it in the old sites of ulceration, I again placed him on the mixed treatment, giving about twenty grains of the iodide of potash daily, with inunctions of mercury, and gave a gargle of hydrastis canadensis. Under this treatment, although he felt quite well otherwise, the throat trouble was gradually growing worse. An extensive expectoration had already set in of glassy mucus; at times it was thick and white, and streaked abundantly with blood; lungs seemed to be normal; cough, that of a laryngeal or pharyngeal trouble; was still unable to get an examination. The pharynx was healthy in appearance, and there was no return of the former ulcerations. Thinking that perhaps edema of the glottis might be the cause of the dyspnea, I felt for it with the index finger, but could detect nothing. I then had him perform deglutition, which took place without difficulty or any great amount of pain. The absence of edema of the glottis, the presence of pain which was seated in the region of larynx, difficulty in phonation, sputa streaked with blood, dyspnea, and the former condition of the patient, led me to the diagnosis of ulceration of the larynx attended with more or less edema. The spray of nitrate of silver, xx grains to the ounce, was used twice daily for a week

by the family, with the exception of three or four times, when I used it myself, but this seemed to aggravate the trouble. He complained of the pustules that the iodide was causing, and it was discontinued. Applications to the larynx by the swab with solution of sulphate of copper were made four or five times, but seemed to aggravate the dyspnea after each application. On the night of the 12th of January I was sent for in great haste, the messenger saying he could not breathe, and they thought he was dying. On arriving at the house I could hear the breathing from the outside, and upon entering, found the patient making great efforts to get breath; the face wore an expression of excitement and agony, as he tossed and rolled in efforts to get air. Inspiration seemed to be about as difficult to perform as expiration; probably inspiration was the most prolonged; pulse 120; temp. 103°, probably due to the excitement and energy exerted at respiration; surface perspiring, phonation entirely absent, expectoration bloody and quite profuse; had not been out of bed for five days, but most always rested better propped up. I gave him steam inhalations with tar water, which may have benefitted him somewhat, but he could not get rest; no appetite; perspiration profuse; became so weak that he was lifted about. He gradually took no nourishment; became greatly emaciated. He passed the night of the 12th inhaling the steam almost continually. On the morning of the 13th I saw him again, and proposed tracheotomy to the parents, to which they readily consented. Thinking that it would be best to wait another day, I did so. On the morning of the 14th I again visited him, and finding the symptoms still aggravated, with a pulse 150, and dyspnea of a very grave nature, so that only about every third or fourth effort at respiration was successful in getting air into the lungs, I determined to perform the operation, as all my efforts seemed be ineffectual in relieving the urgent dyspnea in any other way. At times, I might say, after paroxysms of coughing, attended with extensive expectoration and bleeding, he would feel relieved, and get air much better for an hour. Phonation, as stated above, had been absent for about a week.

The operation of tracheotomy was performed in the afternoon of the 14th, assisted by Drs. Frankenberg and Morrow. Partial chloroform anesthesia was established, the trachea opened, and a silver tube inserted without much trouble or loss of time, and little bleeding. As soon as breathing became easy he lapsed into sleep, which lasted, almost without intermission, for forty-eight hours.

He began to grow in strength from the time of the operation, appe-

tite increased, and he has gained in weight from ten to fifteen pounds. For a month the bloody mucus came from the tube, but finally ceased being coughed out. He was kept upon the specific treatment all the time.

As he grew better and expectoration ceased, efforts were made to get air through the natural opening, but they were fruitless, and a diagnosis of contraction of larynx was made and very unfavorable prognosis given as to subsequent phonation. Tried to get a laryngoscopic examination again, but failed completely, I think on account of some edema of the glottis at this time, attended with the nervous condition of the patient, and his easily excited reflex. Used cocaine spray to no advantage. From this he went on to recovery, but kept on taking the iodide of potassium to iodism at regular intervals.

On the 20th of March I saw him, when he expressed himself as feeling better than he ever had, generally, but was growing impatient about the inability to talk. I advised him to go to someone else and get their opinion about the matter, as I had done all I could, having had him practice daily trying to phonate without success, and at intervals I stopped up the tube, shutting off access of air to the lungs, until he would become frantic for breath, and snatch my hand away from the tube. He had determined to see someone about it the next day, but in the forenoon of that day, on coming down stairs, a friend standing behind the stair door suddenly jumped at him, frightening him; he uttered a sound, and immediately began to talk, which he has kept up ever since.

In regard to the sudden power of phonation, I do not think that that was the result of any change in the larynx, but I think he had been in a condition for phonation for at least a month or more, as it was, at the time he began to talk, nearly two months after the operation; but I think his aphonia lay in an inability to perform the act from forgetting, it may be, how it was accomplished—a sort of an hysterical aphonia, so to speak—as there was no discharge following the phonation, either from mouth or tube.

Phonation was a great surprise to me, as I thought the larynx was perfectly occluded, as on no occasion had air passed through it. The case, I think, is on this account of exceeding interest; he had seemingly tried every means I could suggest without success, and was very anxious over the matter. At present he is in good health, appetite is good, there is no sign of any ulceration going on at the original points of ulceration. He has gained about fifteen pounds since the operation, and says he feels

remarkably well. He still takes specific treatment to avoid recurrence of the trouble.

It is proposed now to take out the tube, cauterize the opening with nitrate of silver, and close the opening with hare-lip pins. I hesitate to do this too soon for fear of the recurrence of the trouble, and a subsequent tracheotomy.

Since the above was written he has had a partial recurrence of the trouble, but is getting along nicely at the present writing.

A HOMEOPATHIC PHYSICIAN'S OPINION OF PROGRESSIVE MEDICINE.
—The *American Lancet* reviews a communication from Dr. F. R. Corson in a homeopathic medical journal. Dr. Corson says he was educated as a homeopath and began practice with profound faith in the doctrines of homoeopathy. Gradually he began to use outside drugs, until at last he uses anything that he has reason to believe will benefit his patients. He repudiates the name of homeopath, and, while he uses homeopathic remedies, he says they are such as are found in the works of regular physicians. He advises homeopathic physicians to send their sons and students to the very best medical colleges in the land. Let them become regular physicians, hampered by no schools, no systems, no therapeutic dogmas—physicians who can practice what their knowledge, their experience, and their conscience may dictate. Drugs should be studied from every standpoint, and be used freely within the limits of prudence and common sense. He divides homeopathists into three classes. First, a very small class, getting smaller daily, composed of strict Hahnemannians, who use nothing outside the strict limits of homeopathy. Second, a much larger class, those who are constantly encroaching upon general medicine, using a great many remedies outside the limits of “*similia*,” and yet who consider themselves homeopathists, and who try to explain their inroads by the laws of similars. Third, a class not so large, perhaps, as the second, yet growing larger and larger every day; those who see they have no rights to the title, and are willing and glad to give it up. They are ready to use anything which science can prove to them to be good. They should be regarded as regular physicians, and should reap all the benefits accruing therefrom.

*BRAIN INJURY OPENING THE LATERAL VENTRICLE.
RECOVERY—HEMIANOPSIA.*

BY J. F. BALDWIN, M. D., COLUMBUS, OHIO.

A Report Presented, with Case, Before the Central Ohio Medical Association,
April 7, 1887.

Andrew Jones, Welch, aged 55, was struck on the head, over the posterior superior angle of the right parietal bone, November 15, 1836. The vulnerating body was a heavy oak beam, projecting from which about two inches was an iron bolt. This beam fell a distance of about sixteen feet, and it is supposed that the projecting bolt inflicted the most serious injury. The skull was broken at the point of impact, the fracture being compound and comminuted, and involving not only the parietal bone but also a considerable extent of the adjoining portion of the occipital. The line of fracture almost reached the superior longitudinal sinus and also the lateral sinus, just before it reaches the temporal bone. The fragments were driven deeply into the brain, and when I saw him, a few minutes after the accident, his hair and clothing gave unequivocal evidence of the loss of considerable blood and brain substance. He was semi-conscious, and vomiting at frequent intervals. Respiration natural; pulse 40. As soon as possible he was removed to his home, when, with the valuable assistance of Drs. Adams, White and Wright and Mr. Cronin, I opened the scalp freely, removed the loosened bones, cleaned out the *debris* as well as possible, put in a drainage tube, and closed the wound. The fragments of bone removed were eleven in number, and together gave an area of $6\frac{1}{2}$ square inches. In removing them I passed my finger into the lacerated and disorganized brain substance to a depth of two inches. At least two teaspoonfuls of the crushed brain came away during the operation. The dura mater was torn to shreds. Dr. Adams administered the anesthetic (ether), and the breathing so nearly failed under its influence that it had to be withdrawn. Indeed, the patient was so nearly dead that the last steps of the operation were hurried lest the patient should die on the table—a contingency which had been fully explained to his friends.

He rallied well from the operation. The vomiting, which had persisted up to the very moment of the operation, never returned. Liquid nourishment was taken freely, and he answered rationally what few questions were asked him.

For several days there was a copious discharge of bloody serum. The drainage tube was removed on the third day. On the fifth day the condition known as *hernia cerebri* set in. The stitches were torn out, by the force of the protruding mass, on the eighth day. On the twelfth day the friends reported a little delirium, and the ominous subsultus tendinum and carphologia appeared. The wound looked well, but it was evident that something was wrong. I therefore opened up one of the flaps, and under it found a little collection of pus. This was cleaned out carefully, and at once the alarming symptoms disappeared. The tendency to hernia persisted for about three weeks, finally subsiding under the pressure exerted by a pad of absorbent wool, snugly bandaged down over the wound.

Soon after the subsidence of the hernia, an intercurrent attack of diarrhea, lasting twenty-four hours, caused such anemia of the brain as to produce a sinking in of the scalp at the seat of injury and a gaping of the wound. The condition was similar to that seen at the anterior fontanelle during wasting diseases in infancy. A part of this depression, however, was due to the loss of brain substance. The recession also revealed the full extent of the injury done to the brain, viz.: there was an excavation in the brain two inches deep, over two inches long, and in the middle half an inch wide. The direction was downward, inward and forward, directly toward the center of the brain, and terminating in the right lateral ventricle by a little slit about half an inch long and an eighth of an inch wide. The width of this excavation varied greatly, depending entirely on the condition of the brain as to amount of contained blood: at times it would gape widely, at others the walls would be almost in contact.

Several physicians saw the case with me, as a matter of professional interest. Of this society, Dr. Halderman saw the case on the twenty-eighth day, and Dr. Wilson on the thirty-seventh.

January 18th, the sixty-fifth day after the injury, Dr. Wilson and myself made careful measurements to determine the exact location of the injury, and also its effects. The wound at this time was nearly closed, having healed up from the bottom slowly until it was now only about half an inch deep.

We found that the wound into the brain commenced at a point 7 centimetres behind the auriculo-bregmatic line, on a level with the superciliary ridge, and terminated 3 centimetres from the posterior extremity of a line 5.5 centimetres long extending backward from the bregma. By

comparing these measurements with fig. 8, of Robert's *Operative Surgery of the Brain*, it would seem that the first and second parietal, angular, and second occipital convolutions were all more or less involved in the lesion.

By reproducing this injury in the brain of a cadaver, I have found that the lateral ventricle is opened just over the *hippocampus minor*.

Motion and sensation, in all its forms, seemed to be unimpaired. The intelligence, so all the friends testified, was unaffected. The special senses were also normal, except vision. There was complete hemi-anopsia, involving the right half of each retina: the eye being fixed on any object, nothing was visible to the left of that object, but everything appeared distinct to the right. In other words, the visual center of the right brain had been destroyed, or its connections with the retina severed.

January 15, the sixty-second day; the wound into the brain has entirely healed; a few drops of pus still issue from a small sinus leading to a little bare margin of bone at the upper border of the fracture. The patient says he feels practically entirely well, and his bodily functions are all normal.

February 18, the ninety-sixth day; slit up the sinus, and removed a small bit of loose bone. The wound thus made I found entirely healed when I called a week later, and I then dismissed the case.

The Treatment of the wound consisted in a daily washing out with a solution of corrosive sublimate, and a dusting of Wyeth's boracic acid powder. The wound was then protected by a pad of absorbent wool, held in place by a night-cap. No constitutional treatment was necessary, except a laxative for the bowels and a few small doses of morphia at night. After the first two weeks, the sublimate was discontinued. During this period, being that when the danger of meningitis was greatest, his temperature never rose above $99\frac{1}{2}^{\circ}$, nor his pulse above 60. In truth, there seemed to be no inflammatory reaction whatever.

I present the patient to you to-day, a little more than twenty weeks since the injury. The deep depression at the site of the fracture indicates fairly well what an amount of brain substance has been lost. His friends assure me that he has suffered no loss of intellectual power, nor has any change in temper or character been observed. There is no evidence of paralysis or paresis; sensation in its various forms seems to be perfect; his special senses are normal, excepting *vision*.

The only effect of his injury is the production of complete half-

blindness, the right half of each retina failing to give any response to light. The condition is technically known as *homonymous hemianopsia*.

In the *Jour. of Mental Dis.* (N. Y.) for January, 1886, Dr. E. C. Seguin gives a succinct tabulation, with a *resume* of the lessons to be gathered from the same, of the 46 reported cases of hemianopsia; the cases are grouped as follows:

Four were indefinite or useless for the study of localization; three were produced by pressure upon optic tracts or chiasm; six were due to lesion of the corpus geniculatum laterale, or the thalamus opticus, or both; 12 were caused by lesion of the white substance of the occipital lobe; five by traumatic lesions of the occipital region of the skull; 16 by lesions of the cortex, or of the cortex and subjacent white substance.

The objects sought from the study are, of course, two-fold: 1. The diagnostic value of hemianopsia alone or joined with other symptoms, such as cutaneous anesthesia, hemiplegia, etc., as pointing out the position and nature of the cerebral lesion. 2. The location of the psychic centre for vision. Concerning the latter point the views of Munk and Ferrier are alone considered as authoritative; according to Munk this centre, as is well known, is held to be in the occipital lobes, each visual area having connections with both retinae. Ferrier held it to be in the angular gyrus. The conclusive cases of the table show Munk's view to be the more trustworthy, and the author finds reason to harmonize the more general position of the two investigators by calling attention to the route of the optic fasciculus of Gratiolet and Wernicke, which, as it passes close under the inferior parietal lobe of the angular gyrus on its way to the occipital lobe, is extremely liable to be severed or interfered with by any injury to the angular gyrus, whence may have arisen Ferrier's error. Charcot's view of a second decussation of the lateral fasciculi through the corpora quadrigemina is discarded as wholly inconsistent with the clinical facts, and it is intimated that Charcot himself has abandoned it. An illustration of the course of the optic tracts without secondary decussation beyond the chiasma is shown, with the ultimate psychic centre for vision located in the cunei and subjacent gyri of the occipital lobes. The following diagnostic laws are tentatively offered by the author as a result and summary of the teachings of the whole discussion:

"1. Lateral hemianopsia always indicates an intracranial lesion on the opposite side from the dark fields.

"2. Lateral hemianopsia with pupillary immobility, optic neuritis,

or atrophy, especially if joined with symptoms of basal disease, is due to lesion of one optic tract, or of primary optic centres on one side. This diagnosis may be further strengthened and rendered quite certain by seeking for and finding one-sided pupillary reaction, as recently suggested by Wernicke. He ingeniously predicts that one lateral half of each iris will be found to contract by the reflex effect of light when one optic tract has been interrupted. He designates this as 'hemioptic pupillary reaction.'

"3. Lateral hemianopsia, or sector-like defects of the same geometric order, with hemianesthesia and choreiform, or ataxic, movements of one-half of the body without marked hemiplegia, is probably due to lesion of the caudo-lateral part of the thalamus, or of the caudal division of the internal capsule.

"4. Lateral hemianopsia, with complete hemiplegia (spastic after a few weeks), aphasia if the right side be paralyzed, and with little or no anesthesia, is quite certainly due to an extensive superficial lesion in the area supplied by the middle cerebral artery; we would expect to find softening of the motor zone and of the gyri lying at the extremity of the fissure of Sylvius, viz., the inferior parietal lobule, the supra-marginal gyrus, and the gyrus angularis. Embolism or thrombosis of the Sylvian artery would be the most likely pathological cause of the softening.

"6. Lateral hemianopsia, with moderate loss of power in one-half of the body, especially if associated with impairment of the muscular sense, would probably be due to a lesion of the inferior parietal lobule and gyrus angularis, with their subjacent white substance, penetrating deeply enough to sever or compress the optic fasciculus on its way to the visual centre.

"7. Lateral hemianopsia without motor or common sensory symptoms. This symptom alone is due, I believe, from convincing evidence, to lesion of the cuneus only, or of it and the gray matter immediately surrounding it on the mesial surface of the occipital lobe, in the hemisphere opposite to the dark half fields. Most surgical cases come at once, or after convalescence, within this rule, or in 6."

In all cases coming under 3 to 7 inclusive, the pupils react normally; and rarely does the ophthalmoscope show any lesion of the optic nerve, except, of course, in some tumor cases, when neuro-retinitis may be expected. In the August number of the same periodical Dr. Seguin reports nine bases of hemianopsia in which no post-mortem examination existed to confirm the results of the study of the cases previously examined.

Pathological diagnoses are put forward according to the analysis of previous cases submitted to post-mortem investigation. Two notable symptoms are discussed: the existence of hallucinatory images in the half fields that had just become blind, explained as the irritation of the cortical visual center just previous to its destruction; the preservation of central vision in all cases of hemianopsia, the hemianopic half field always stopping just without the macula.

The case before us, then, would *seem* to come under the seventh division. But we can almost certainly exclude any injury of the cuneus. We must therefore conclude either that Ferrier was right in placing the visual center in the region of the angular gyrus, or that an injury in this region may effect division of the fibres of the optic fasciculus, on their way to the cuneus, without producing either paralysis or anesthesia.

The real lesion in this case can be only approximately determined from the data I have been able to give; but it is to be hoped that ultimately, when our patient pays the debt of nature, an opportunity will be afforded for a thorough investigation.

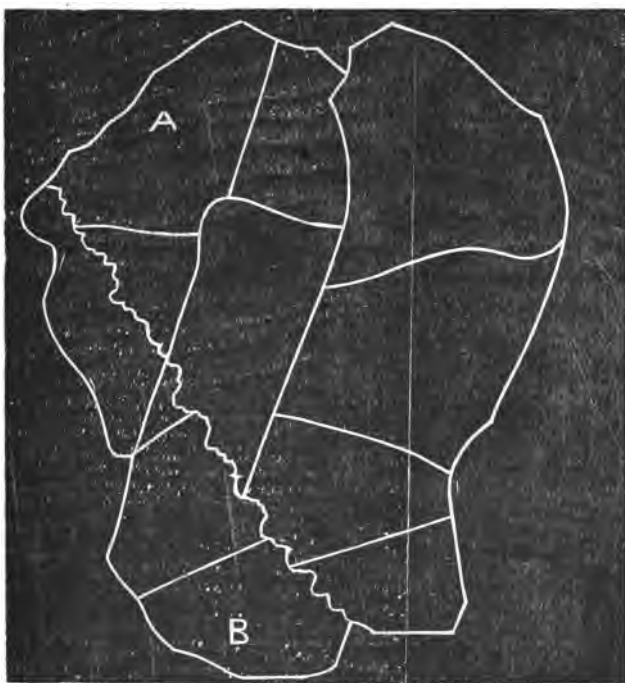


Fig. 1.

Showing the size and shape of the fragments of bone removed. The waving line shows the occipito-parietal suture. A and B show the portions lying in close proximity, respectively, to the longitudinal and right lateral sinuses.

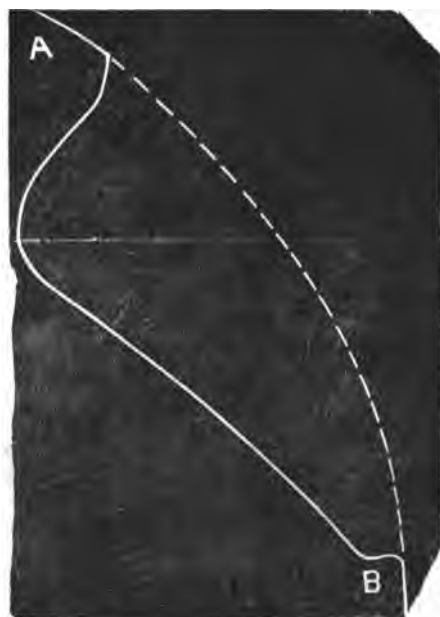


Fig. 2.

Showing the depth and general outline of the depression now existing at the seat of injury, from above downward. A and B represent respectively the upper and lower borders of bone, and the dotted line the normal contour of the skull. The degree of depression varies greatly, depending on the state of the blood-supply of the brain.

RIGOR mortis is generally ascribed to the hypothetical coagulation of myosin after death. In a recent communication to the French Academy of Science, Brown-Sequard shows that if blood is injected in rigid limbs the rigor disappears immediately, and reappears when the introduction of blood ceases. He has noticed the phenomenon even twenty-eight days after death. If a limb is kept in a state of constant agitation by means of some mechanical contrivance, during the first eight hours after death, no rigidity appears. He also notes the fact that cadaveric rigidity does not affect nervous excitation. While Brown-Sequard does not believe in the myosin coagulation theory, he does not give us any very definite theory in its stead; but he thinks that muscular tissue retains after death a particular sort of vitality.

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OBSTETRICS.

THE USE OF THE FORCEPS.—(Prof. Goodell in the *Med. Bulletin*.) The immense majority of the profession deliver the head all the way through with the forceps. Young practitioners are not capable of doing this. The proper plan in the great number of cases is to bring the head down to the perineum with the forceps and make it bulge, and then take off the forceps and let nature deliver the case. She will do it much better than you can. It takes a man with a great deal of coolness, judgment, and experience to deliver the head all the way through with the forceps. Some years ago I was invited to a neighboring city to attend a gathering of physicians. In the course of the evening, the subject of the forceps came up. I expressed the same views that I have just now. One of the gentlemen criticised my plan pretty sharply, and held that the perineum could be saved by the forceps. This is true in certain cases. Another member also opposed the method pretty strongly. Before six months had elapsed I was sent for to go to this place and sew up a perineum torn right through the sphincter by one of these gentlemen. Before the year was up, the other gentleman sent for me for a similar purpose. My rule, which I almost invariably follow, is to remove the forceps when the edge of the perineum begins to grow tense and looks as though it might yield.

Suppose you do meet with a laceration of the perineum, put in the stitches at once. Do not conceal the accident. If you have taken the forceps off as I have suggested, it cannot be said that the instrument was the cause of the tear. These tears always look worse immediately after labor than they do the next day. When you are in doubt, put in a stitch. I should advise you to always carry needles of sufficient length. Make it a rule always to examine the perineum after labor, for if you do not you will be caught some time. I shall never forget the case of a gentleman of large experience who had been tugging away at the head for a long time until he was completely demoralized. He then sent for me, and I worked until at last the head was on the perineum. When the perineum began to bulge, I handed the forceps to him, expecting that he would simply bring the head a little further and then remove the forceps. But, as often happens under such circumstances, he had become demoralized. Indeed a French physician has written a rather exaggerated article on the delirium of physicians, in which he re-

fers to the demoralization by long-continued wearisome work by the side of a patient, and mentions some very extreme instances. The physician to whom I have referred, at once turned the head out, and after delivering the woman went to wash his hands. I examined, and found a tear completely through the sphincter, and great was his astonishment when I called his attention to it. We sewed it up and it united perfectly. In many cases of laceration neither the physician nor the patient is aware of the injury until the bowels have been opened. The examination should always be made with the finger in the rectum and the thumb in the vagina. In this way the tear will not be overlooked. If the tear is through the sphincter, I should advise that you do not perform the operation without assistance, unless you have a trustworthy woman on whom you can rely. It is necessary to give ether.

In performing the operation, the parts should be cleansed and a sponge introduced into the vagina to prevent blood trickling down and obscuring the parts. It is not easy, especially at night, to distinguish the torn parts from the undenuded, congested structures. The sutures should, if possible, be buried. In regard to the management of the bowels, I am a little uncertain. Where the tear does not extend through the sphincter, it makes little difference whether the bowels are opened at the end of four days or at the end of a week. When the tear involves the sphincter, it is an important question whether the bowels should be kept open or bound. I have been quite successful in this operation, and I have kept the bowels bound from eight to eleven days. I remove the stitches on the eighth day, and then wait three days longer before opening the bowels. In the evening, I employ an injection of one ounce of glycerine with one or two ounces of sweet-oil, and the following morning give a dose of castor oil. I once had the perineum torn when the bowels were opened. I have also had the sphincter torn open a little so that it was not as perfect as it should be. In my later cases, I have been using the method of opening the bowels after three full days by the use of small doses of sweet oil, and then waiting until the end of a week before again opening.

Let me say a word with reference to supporting a perineum. The perineum is not what needs support. It is the head. The perineum is the elastic ring through which the head must come, and you want to let it religiously alone. By placing the hand upon the head, you can keep it from descending. This is aided by telling the patient to cry out when she has the pain. Suppose the head comes down and the perineum

looks as though it must give way, are you justified in making lateral incisions? I think so. I do it occasionally. It at least does no harm. It can be done with a blunt-pointed bistoury during a pain, and if a stitch is put in will heal quickly.

Where the perineum is rigid, ether may be used. During a long labor, the patient becomes worn out and nervous. As a result of the nervousness the perineum becomes dry. Warm water, with plenty of vaseline, will soften it; as a French physician has said, all that is necessary is plenty of grease and more patience. Ether aids in relaxing the parts. It has also the advantage of giving you complete control over the labor. When I say ether, I mean chloroform. As soon as the patient feels the pain, a few drops of chloroform may be put on the towel, and a few whiffs obtunds the pain. Chloroform, I think, does not interfere with the secretions as much as ether does. In my opinion, chloroform is the anesthetic to be used in labor.

ROTHELN, OR "GERMAN MEASLES."—In a lecture before the Association for Internal Medicine in Berlin, Dr. A. Klaatsch, after a review of the literature of the subject, describes this disease as observed by himself in two epidemics, the first of which occurred in 1861, the second in 1884-'85. During the latter epidemic he had the opportunity to observe forty instances of the disease, occurring in seventeen families, the majority of which cases had already had measles.

The manifestations of rotheln are those of a mild disease, and the eruption appears, as a rule, without any prodromata. As is the case with all the exanthemata, the eruption may be of various grades of intensity, and every stage from the ill-defined and incomplete, to the well-marked and characteristic form of eruption, may be witnessed. In typical cases the body is covered with highly colored red spots, universally distributed. There are two different forms of eruptions. It may either be punctated in appearance, and resemble a collection of numerous small dots made with a pin dipped in red ink, or it may consist of larger spots of one-half to one centimeter in diameter, which are of lighter color in the center than in the periphery. These maculæ are not circular in shape, like those which form the eruption of measles, but are nearly always possessed of a border, which is irregular and composed of projecting angles and indentations, which may be discerned, even when the eruption is very thickly distributed, and in such cases, also, the individual lesions are separated by skin of normal appearance. The author is

unable to state with certainty whether the larger form of eruption is developed from the smaller, although, in some instances, such seemed to be the case. As a rule, the eruption is manifest over the whole body, from head to foot, being most marked, however, upon the face, the shoulders, the extensor surface of the arms, the lower part of the back, and on the buttocks. The color of the eruption is generally less vivid upon the lower than upon the upper part of the body. Sometimes portions of the body, such as the face, remains entirely untouched by the eruption, and occasionally it is grouped in an irregular and limited manner. One of the most striking instances of curious distribution of the eruption was the case of a boy, in which only the lower part of the body below the waist was affected. In another case, the eruption formed a red band around each thigh. Oftentimes the skin between the individual lesions of the eruption is reddened by erythema, so that the whole skin is of a uniform redness, reminding one of scarlet fever. A coalition, however, of the individual lesions, such as takes place in measles, has not been observed by the writer. Occasionally these maculæ are so thickly distributed that the whole cutaneous surface appears of the same red color, and it is only by pressure with the finger and the production of temporary anemia, that the individual lesions may be detected, as the redness of the skin reappears. Occasionally minute pustules are developed upon the hyperemic base furnished by the eruption. A hemorrhagic variety of eruption, such as occurs in measles, has never been seen by the writer, but the eruption, however, if of an intense character, may leave behind it a yellowish discoloration of the skin, which lasts for some time. It is only in rare instances that the appearance of the eruption was accompanied by itching. The eruption follows the same course of development as that of measles, appearing first upon the head, and afterwards upon other parts of the body, but its spread takes place much more quickly than is the case in measles, often twelve hours, and rarely more than twenty-four hours being sufficient time for its entire development. As a rule, lasting about three days, and in severe cases five days, its departure is as rapid as its appearance.

In about one-half the cases of the disease there was rise of temperature rarely reaching 36° C., which made its appearance with the eruption and continued for one day only, while the general subjective feelings of the patients were in no way disturbed. As constant and accompanying symptoms, were observed injection of the conjunctivæ, reddening of the pharynx and enlargement of the lymphatic glands. The ex-

pression of the eyes was peculiarly dim, but there was observed neither photophobia nor hypersecretion of tears. The redness of the pharynx was diffuse, not spotted, as in measles, and was confined in its distribution to the back wall of the pharynx, the pillars of the fauces, the tonsils and the lower part of the soft palate. In no case was there observed any severe "sore throat" as a result of this reddening of the mucous membrane of the same. Almost characteristic of the disease was the well-marked enlargement of the cervical lymphatic glands and the lymphatic glands over the mastoid processes, which could be detected in every case without exception. A similar enlargement of the lymphatic glands has never been observed by the writer in connection with measles. In most of the cases of rotheln there was also moderate enlargement of the lymphatic glands, in the axillæ and groins. This enlargement of the lymphatic glands, however, does not occur in all epidemics, since Thomas, who observed the disease very carefully, expressly states that he was unable to make out any enlargement of the lymphatic glands.

While the course of the disease occurring in children who have been previously in good health, is always a favorable one, a few cases of death were observed in children already sickly and debilitated from other causes. The writer considers the disease to be contagious but to a limited degree since he has repeatedly observed instances where the disease was confined to one child of a family. The most marked expression of its contagiousness was furnished in a girls' boarding school. One of the scholars having been attacked, all the other inmates were sent home, and of these eleven were attacked by the disease. The apparent incubation of the malady, as far as could be made out, varied from fourteen to twenty-two days. The disease was not confined to children, the writer having met with it eight times in persons of from eighteen to thirty-five years of age.—*Arch. of Ped.*

CICATRICAL PLUG OF EMMET.—(Editorial in *Md. Med. Journal*.) Dr. T. A. Emmet, of New York, was not only the first observer to call attention to the cervical lacerations upon the female economy and to propose operative measures for the relief of the same, but to him is the profession likewise indebted for the recognition of the fact that the cicatricial tissue often formed in the angles of the cervical lesion is as potent a cause of reflex disturbances of the nervous system as is observed in those cases where no attempt at a repair of the laceration has been made by nature.

Injuries to the cervix uteri during childbirth assume many different relations to the subsequent history of the individual who has sustained them, and may be viewed from a number of standpoints. Dr. Emmet doubts whether a woman can give birth to her first child without some laceration of the cervix uteri taking place. If this be a fact—we are not able to deny it—the cervical wounds are so many mouths remaining open after childbirth for the escape of blood, for septic absorption and for subsequent cicatrization. These lesions may have a subsequent influence upon the health of the individual out of all proportion to their gravity. Lacerations in the median line through the anterior and posterior lips of the cervix almost invariably heal by primary union. In the uni-lateral or bi-lateral tears extending deep into the tissues of the cervix no such favorable union is likely to take place. The flaps are almost sure to separate, and if closure results the union is by granulation and slow cicatrization. The process of repair is not infrequently accompanied by the formation of dense cicatricial tissue in the angles of the tear which by partially or completely filling up the gap draws the separated lips together. In every long-standing laceration of the cervix more or less of this fibrous tissue will be found. It is quite true its presence has been denied by some writers, but others, including such authorities as Emmet, Goodell and Munde, are just as positive of its existence and of its causative influence in the production of reflex disturbances. In point of fact the failure to recognize the existence and the influence of this cicatricial tissue has a ready explanation in the indisposition upon the part of some observers to investigate carefully for the lesion and an apparent unwillingness to assign to it a pathological influence. It cannot be denied that cervical lacerations frequently occur—remain open or close by cicatrization—without any apparent injury to the health of the woman. Child-bearing may continue or sterility may be the result, the patient remaining in ignorance of a pathological condition of her generative organs. The significance of a uterine lesion is often determined by the subjective symptoms rather than objective phenomena. There is an abundance of clinical evidence to show that reflex troubles are not dependent upon the extent or special character of the uterine lesion. This fact is fully illustrated in the clinical history of many women who have a “cicatricial plug” in the angles of an old lacerated cervix. The way in which this cicatricial tissue induces trouble, is thus explained by Munde: “The dense cicatricial substance, by compressing the terminal nerve filaments, gives rise to multitudinous and diverse reflex neuroses in other parts of the body.”

Dr. Emmet says "after nature has repaired the injury by partially or completely filling the gap between the flaps by cicatricial tissue formed in the process of healing by granulation, marked reflex disturbances will sometimes be established." There can be little doubt, we think, of the pathological influence of cicatricial tissue in a certain number of cases in which lacerations have occurred and due consideration should be given to its causative influence in provoking reflex troubles. We must ignore important clinical observation and teaching if we fail to regard the lesion in question.

This subject has recently been discussed in a very careful and thorough manner by Dr. W. E. Mosely. In a paper read before the Alumni Association of the Woman's Hospital, (*N. Y. Medical Journal*, July 24, 1886) entitled "The Influence from a Clinical Standpoint of Cicatricial Tissue in the Angles of the Lacerated Cervix," Dr. Mosely undertakes to show, by way of exclusion, the influence that hard, or so-called cicatricial tissue, deep in the angles of the lacerated cervix, has in causing many nervous phenomena, such as headaches, general neuralgias, and general nervous irritability, which have been commonly included under the head of reflex nervous symptoms, and in causing, or at least perpetuating, the anemia which almost invariably mark those cases of neglected laceration in which we are called to operate. To establish his position Dr. Mosely falls back upon clinical data. He furnishes clinical evidence in support of his views and convictions which will be difficult, if not impossible to controvert. Dr. Mosely has been able to demonstrate that in certain cases, at least, certain morbid conditions of the nervous system resulted from the presence of this cicatricial tissue, and that relief followed its thorough eradication.—*Arch. of Gynecol.*

A REVIEW OF TWENTY-TWO COTTAGE CASES OCCURRING IN THE WOMAN'S HOSPITAL, IN THE SERVICE OF DR. T. GALLIARD THOMAS.—Dr. A. H. Buckmaster, in the April number of *The American Journal of the Medical Sciences*, describes the technique of antiseptic laparotomy as practiced by Dr. Galliard Thomas, in his wards at the Woman's Hospital. All taking part in the operation, including the nurses, wash their arms and fore-arms carefully with soap and water, paring the nails and using a nail-brush. The hands are dipped into a solution of bichloride of mercury (1:2000) and a basin containing a solution of the same strength is within easy reach, so that the operator may cleanse his hands from time to time, particularly before introduction into the peritoneal cavity.

All instruments are placed, for an hour before the operation, into 1:20 carbolic acid solution, to which an equal quantity of sterilized hot water is added when the instruments are in use. The water is taken from the tank of a high pressure boiler, and carried to the operating-room in demijohns.

The same sponges are used continuously, and to each is sewed a piece of tape, so that it is almost impossible to overlook them when closing the abdominal cavity. After an operation the sponges are carefully washed with soap and water and then boiled for several hours. They are preserved in a glass jar with an air-tight cover, and rest upon a false bottom composed of galvanized rubber which is perforated, and stands in a solution of carbolic acid, 1:20. Before use they are soaked for two hours in bichloride of mercury 1:1000. If a sponge becomes friable, or is difficult to clean, it is replaced, and a new one is prepared by soaking it in a very weak solution of hydrochloric acid for several weeks.

For ligatures and sutures silver wire is used, rendered aseptic by immersion, with the instruments, in the solution of carbolic acid before an operation. Of catgut, that prepared by Am Ende is preferred. It is preserved in oil of Juniper. No. 3 is the size most used, and Nos. 4 and 5 are at hand. The silk for the pedicle and ligatures is prepared in the following manner: A piece of solid glass rod is bent in the form of a square, and on this the ligature is rolled, so that all parts are evenly exposed to the boiling solution of 1:2000 bichloride of mercury, in which it is suspended for an hour. It is removed from this solution under the spray (the utmost cleanliness as to the hands being observed) and dropped into a solution of carbolic acid 1:40. Under the solution it is reeled on a glass spool, and finally placed in a bottle containing 3 per cent. of carbolic acid in alcohol. The bottle, cork, and glass spool are boiled with the ligature. The end of the ligature is carried through the cork by means of a carrying thread attached to a round-pointed needle: all of these articles have been rendered aseptic.

Before an operation the walls, flooring, and everything in the operating-room should be rubbed with a cloth wet with the chloride of lime, 1:10, and the doors and windows thrown open for twenty-four hours, so that there may be the freest circulation of fresh air. For an hour and a half two spray apparatuses saturate the air with a solution of carbolic acid, 1:40. The solution used is about 1:20, but it loses about one half its strength by dilution with the steam. The spray is discontinued when the operation commences.

To guard against contamination from spectators, a rope is interposed, at least three feet from the wound.

The abdominal wall is shaved low enough to prevent the pubic hair from reaching the wound, and the abdomen washed with soap and water and covered with a towel wet with a solution of bichloride of mercury, 1:1000. This is removed just before the operator makes his first incision.

To prevent auto-infection from cysts containing septic material, the patient is turned on the side when they are evacuated.

The preparation of the patient for the operation, the method of operating, and the after-treatment are, also, fully described and illustrated by the notes of twenty-two cases.

TREATING STERILITY IN THE FEMALE.—It is customary for mariners now and then to take observations by the way, that they may ascertain the distances they have sailed, and how far they may have drifted from the proper track.

So with physicians it is not unwise from time to time to compare results under treatment with those which nature gives without interference. The propriety of this move may impress itself upon well-nigh all lines of practice, but just now we propose to ask what results the step yields to gynecologists in the treatment of sterility in the female. Physiology teaches us that the healthy spermatozoid in a normal vagina and uterus may live and retain its power of motion for a period of seven or eight days. Its lateral diameter is about $\frac{1}{4200}$ of an inch, and therefore it will be able to penetrate any orifice through which a red blood cell may pass. Its rate of movement is about one inch in seven and a half minutes, or eight inches an hour. This is sixteen feet a day, or between thirty and forty yards in its short lifetime.

It is quite certain that a spermatozoid seeking the ovule of its affinity could stop at all the way-stations, even do considerable loitering by the wayside, and then reach the ovary in full vigor.

In view of this speed and endurance of travel on the part of the spermatozoid, we might well ask how many women to the million there are whose uterine cervixes are too long to be traversed by them, and thus require amputation that the route may be shortened.

Again, in the matter of flexions, where often menstruation is profuse, it is difficult to realize the need of such treatment as even eminent gynecologists have recommended merely to insure the entrance of the spermatozooids. The cases of flexion must be very rare in which the os is

pressed laterally against the walls of the vagina with such force as to preclude the entrance of spermatozoids. As a matter of fact, there are perhaps few physicians who have not met with cases where the fundus is the first thing that presents itself to the touch on examination, and yet with pregnancy occurring regularly. It is true that abortion takes place almost invariably if there are adhesions, but still the fact of fecundation in that state remains. We are very far from asserting that no cases are amenable to treatment, but we insist that the conditions are so complex, and require so much knowledge and care, that the great majority of women so affected would do better without than with such treatment as they receive. In acrid conditions of the vaginal secretions, in cases where urinary fistulæ allow the frequent contact of urine with the vagina and cervix, in all physical derangements that produce real obstructions or the effusion of destructive secretions, of course treatment may and often does do good. But we are too apt to forget that many women delay child-bearing for years after marriage, and then, without any treatment whatever, bear children and even become prolific. It is not a rare thing at all for two or three years or more of married life to pass before conception takes place, and cases have been reported in which the first child was born twenty-five to twenty-seven years after marriage.

Whoever may happen to be treating such cases at such times gets great credit for bringing about a condition of fertility. We remember once to have had occasion to treat for malaria a barren woman who had been fifteen years married. She had the ordinary routine treatment of a purgative followed by quinine. The medicine not only cured the malaria, but had also the credit of adding a baby to the joys of the household, the woman having conceived shortly after.

We have met with another case wherein a first child was born twenty-five years after marriage. If some aspiring gynecologist had had the good fortune to give this woman a dose of castor-oil upon the eve of her silver wedding, with what good reason might he have congratulated himself that some other aspiring gynecologist had not been permitted to spay her.

Too often it happens that our successes, limited as they are, comparatively speaking, are but coincidences, and it may not infrequently happen that, instead of promoting fecundity by our surgery, we really impair it.—*Amer. Prac. News.*

A DOMESTIC NIPPLE SHIELD.—Dr. Frank Holyoke states that a patient who suffered from extremely sensitive fissured nipples invented for herself most perfect nipple shields, by suspending, from a ribbon about her neck, two wire tea-strainers. They were held in place by a properly-fitting waist, and the nipples, thus covered, were entirely free from any irritation, and were also kept dry, as there was a ready passage of the milk through the wire gauze to a layer of absorbent cotton covering the tin-strainer. Not until she began to employ this method of the protecting nipples did the process of healing go on satisfactorily.

THIRST IN YOUNG INFANTS.—Touissaint in *L'Union Med. du Can.*. It is a mistake to suppose that because milk is a liquid food it is at the same time a drink which is capable of satisfying the thirst of infants. Although milk appeases hunger, it makes thirst more intense after it has stood awhile in the stomach and digestion of it has begun. It is thirst which causes healthy, breast-nourished infants to cry for long periods of time in many instances. There are many cases of indigestion due to weakness or insufficiency of the child's gastric juice which would be greatly benefitted or even cured if the child was allowed an occasional drink of water.—*Arch. of Ped.*

COCAINE IN URETHRAL CARUNCLE.—Dr. J. D. Worsham, *Journal Amer. Med. Assoc.*, reports the case of a girl, who has been helpless for one month with a urethral caruncle. She was lying on the back unable to move for the pain. He applied a 5 per cent. solution of cocaine and removed the growth with one sweep of the knife. The cocaine acted within five minutes, rendering the caruncle painless, and before he left the house the patient was out of bed and walking about the house. There was no pain during or after the operation, and the hemorrhage was inconsiderable.

DR. LUSK, New York, according to the *Southern California Practitioner*, said in a recent lecture that he knew oophorectomy was being performed too often in New York. The operator would take out a slightly enlarged roughened ovary, and triumphantly display it to the onlookers, and say, 'see the cystic degeneration!' when the cysts were only the normal graffian follicles, and the roughness the normal cicatrices of the corpora lutei. The trouble with oophorectomists was they never went to the deadhouse to find out what a normal ovary was, but believed in an ideal velvety ovary which is only found in the girl before puberty.

A SUBSTITUTE FOR STRAPPING THE BREAST.—Dr. H. T. Bahnson, of Salem, N. C., recognizing the impossibility of suitably applying support to an inflamed breast by adhesive plaster or other means generally recommended, several years ago hit upon the idea of using pure rubber tissue, such as is used by dentists. A square piece, sufficient to completely cover the affected breast, is laid over it, and such pressure as is comfortable to the patient, is effected by means of a tape tied to each corner of the square rubber tissue. Two of these tapes pass around the waist; the other two are brought, one over the shoulder of the unaffected side, the other under the arm of the opposite side, or vice versa, as is more comfortable to the patient. A very small opening is made for the nipple. The relief is wonderful, and he is confident he has aborted the trouble in a large number of cases. Even after an abscess has formed, the application is most efficacious. The abscess can be opened through the tissue. The complete evacuation of pus, as well as the prevention of burrowing and extension of inflammation, are better effected by this than any other means.—*Practice.*

PAINFUL MENSTRUATION.—Having found the following formula a good one in cases of amenorrhea and dysmenorrhea, I send it for publication, thinking perhaps some of your readers might be seeking for something of the kind. It is *not* a specific, but the nearest approach to it of anything I have ever found for the above named difficulties. *For a four ounce mixture :*

R. Fl. ext. cimicifuga,..... $\frac{3}{4}$ ss.
 Fl. ext. pulsatilla,..... $\frac{3}{4}$ ss-j.
 Fl. ext. Yerba Santa,..... $\frac{3}{4}$ j.
 Syrup simp., ad..... $\frac{3}{4}$ iv.

Sig.—One teaspoonful every one or two hours to six doses, unless flow is sooner established.

I find the recipe of most use in women of a nervous temperament. Of course, if there is any self-evident cause for the menstrual trouble, that should be removed; but we often find the trouble existing in young girls in whom the flow is imperfectly established, and who will not consent to an examination.—A. A. NEFE, M. D. in *Med. and Surg. Reporter.*

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* These combinations are largely used by the profession.

* Acid Phosphate with Strychnia.

R
Horsford's Acid Phosphate $f\frac{3}{4}$ viij
Strychninæ Sulph $gr. j$
M

Sig: Half to one teaspoonful in a glass of water.

Acid Phosphate with Quinine.

R
Horsford's Acid Phosphate $f\frac{3}{4}$ ss
Quininæ Sulph. $gr. xvj$
Syrupi Simplicis $f\frac{3}{4}$ ij
Aquæ $f\frac{3}{4}$ ss
M.

Sig: A tablespoonful in a wine glass of water.

Acid Phosphate with Emulsion of Cod Liver Oil.

R
Emulsion Olei Morrhuæ 50% $f\frac{3}{4}$ vij
Horsford's Acid Phosphate $f\frac{3}{4}$ j
M.

Sig: A tablespoonful.

* Acid Phosphate with Wine of Pepsin

R
Vini Pepsinæ $f\frac{3}{4}$ vj
Horsford's Acid Phosphate $f\frac{3}{4}$ i j
M.

Sig: A dessertspoonful in water.

Acid Phosphate with Elixir of Iron and Quinine.

R
Elix. Ferri et Quininæ
Horsford's Acid Phosphate $aa f\frac{3}{4}$ iij
M.

Sig: A teaspoonful in water.

* Acid Phosphate with Tincture Nux Vomica and Compound Tinc- ture of Gentian.

R
Horsford's Acid Phosphate $f\frac{3}{4}$ vj
Tinct. Nucis Vom. $f\frac{3}{4}$ j
Tinct. Gentianæ Comp. $f\frac{3}{4}$ ij
Syrupi Simplicis $f\frac{3}{4}$ iij
M.

Sig: A tablespoonful in water.

We do not prepare the Acid Phosphate in any of the above combinations.

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MEDICINE.

INFLUENCE OF CASCARA SAGRADA ON THE DIGESTIVE SECRETIONS.—Dr. Tschelzen, who has studied cascara sagrada experimentally, has arrived at the following conclusions, which he publishes in the *Journal de Medicine* :

1. Cascara sagrada is efficacious when a prompt cathartic action is looked for.

2. It acts as a purgative only after it has been introduced into the stomach : when injected into the skin or into the vessels, it does not cause an intestinal evacuation.

3. It does not increase the salivary secretion.

4. It causes an increase of the gastric juice which is often continued during the process of digestion ; it increases also the biliary and pancreatic secretions.

AN EXPERIMENTAL RESEARCH UPON RABIES.—Dr. Harold C. Ernst, having received two rabbits which had been inoculated in Pasteur's laboratory, undertook to prove experimentally the following propositions :

(1) Is there a specific virus in the brains and cords of rabbits inoculated with Pasteur's material and after his methods ?

(2) Does the treatment by drying, proposed by him, modify the strength of his virus ? And, finally,

(3) Does injection with such "modified virus" produce an immunity against an inoculation (or bite) with virus of full strength ?

His results with the experiments in detail appear in the April number of *The American Journal of the Medical Sciences*. Dr. Ernst began the investigation as a sceptic, but his experiments seem to justify a change from scepticism to a belief in, at least, a portion of Pasteur's assertions.

The conclusions which Ernst draws from his experimental work he summarizes as follows :

I. There exists in the cords and brains of animals inoculated in Pasteur's laboratory a *specific virus*, capable of the production of similar symptoms through a long series of animals.

II. That these symptoms are produced with absolute certainty when the method of inoculation is by trephining the skull, and injection under the dura mater, with less certainty when the inoculation is by subcutaneous injection.

III. That the strength of this virus is lessened when the cords con-

taining it are removed from the animals and placed in a dry atmosphere at an even temperature.

IV. That the symptoms produced by the inoculation of this virus only appear after a certain period of incubation, distinctly shorter when the inoculation has been done by trephining, than when done by subcutaneous injection.

V. That injections of the virus, modified in strength by drying, and in the manner prescribed by Pasteur, exert a very marked protective influence against an inoculation with virus of full strength.

VI. That a very moderate degree of heat destroys the power of the virus entirely, whilst prolonged freezing does not injure it.

As will be seen, all of these conclusions are in complete accord with the declarations of Pasteur; their importance lies in the fact that they were reached at a distance from him, and by work entirely separated from any personal influence or bias.

SOLUBILITY OF MORPHINE IN LIME WATER.—Doubtless many physicians who have given sulphate of morphine in solution of lime-water have not settled in their minds the chemical compatibility of the mixture. Some recent experiments in the assay of morphine, by Wrampelmeiner & Meexert, show the mutual solubility of lime-water and morphine.—*Med. News.*

THE TREATMENT OF PULMONARY DISEASES BY GASEOUS ENEMATA.—(Edward S. Bruen, M.D., Asst. Prof. Physical Diagnosis, University of Pennsylvania, and one of the physicians to the Philadelphia Hospital, in *Med. News*, April 2, '87.) In the Philadelphia Hospital for the past seven weeks, the treatment of various forms of pulmonary disorders by the use of carbonic acid gas impregnated with sulphuretted hydrogen has been practiced, according to the plan inaugurated by Dr. Bergeon, of Lyons. The twenty-five cases of phthisis chosen on which to make a trial of the gas, included mostly patients suffering from advanced lesions, nearly all associated with cavities, marked bronchial catarrh, and some laryngeal lesions. At this time we are engaged in making a series of critical observations in reference to many essential features bearing upon the permanent value of the treatment, such as the best mode and frequency of the administration of the gas, the quantity and quality to be employed, and the effect upon the sputa, including the bacillus of tuberculosis. Our investigations into these subjects are still in progress; moreover, time is necessary to secure a proper estimate of the permanent beneficial effects.

of the treatment upon the lesions in the lungs. This report is, therefore, preliminary in character, and designed simply to record the results thus far secured.

The histories of the cases under treatment have shown that the element of suppuration, as it occurs in the pulmonary cavities, and in the bronchial passages, has been positively and promptly antagonized. The temperature has been reduced in a few days, and within two weeks has frequently been brought to a normal point. In grave cases with advanced pulmonary lesions, the temperature has continued to rise a degree or so above the normal standard, but during the period of treatment in more than twenty cases, the temperature chart has always been positively modified.

Together with the reduction in temperature has followed the cessation of night-sweats in most instances, and in all, this symptom has been markedly lessened. In cases in which evidences of bronchial catarrh have been present, such as rales, and copious muco-expectoration, the rales have disappeared, or have been decidedly decreased; and in nearly all instances the digestive system has been favorably affected, the tongue has become clean and natural, the appetite has increased, and also the ability to assimilate and appropriate food.

In most cases the gain in weight has been progressive and considerable, and the nervous symptoms incident to phthisis decidedly influenced for the better, and a more cheerful disposition secured. The immediate effect of the introduction of the gas upon the pulse, has been to lessen it by fifteen to twenty beats and the respiration *temporarily* increased. The pulse-rate has subsequently been proportionate to the general condition of each individual case.

A woman aged forty, entered the Philadelphia Hospital February 5th, with entire consolidation of the left lung of the variety frequently described as catarrhal or broncho-pneumonia. She had taken cold in December, 1886; had previously been a healthy, rather stout woman. The following symptoms, as abstracted from the clinical history, were present: Abundant muco-purulent expectoration, more than a pint in twenty-four hours; profuse sweats; pulse 120, temperature ranging from 100° to 103°; anorexia, with coated tongue, and inability to receive and appropriate food. After treatment with the gas, administered twice daily since February 10th, she now seems to be convalescent. The temperature is normal, pulse 90, appetite excellent, and flesh increasing. The apparent beneficial effects were noticed within the first week, but it was

four weeks before the patient was free from fever. The appetite improved within a few days from the first employment of the treatment, and simultaneously, the nervous symptoms, such as hysterical tendencies and excitement, disappeared. In this instance all treatment, except the gas, was suspended. At this date the pulmonary lesions seem to be disappearing, and the lung seems to be approaching the normal condition once more.

Four other cases among the group seem deserving of special mention. One of these is a case of basic cavity, involving almost the entire left lower lobe. In this case the effects of the gas treatment upon temperature, sweating, appetite, etc., were conspicuous, and the gain in flesh the first four weeks was two pounds per week, but during the last two weeks there has been a loss of two pounds, although the other symptoms continue to improve.

Another case, also one of basic cavity, with marked pleural thickening, copious muco-purulent expectoration, but without other pulmonary lesions; in a word, a case suitable for treatment by the introduction of a drainage tube. The same good effects were noticed, yet although this case has been under treatment for several weeks, the temperature still remains somewhat above normal, and the secretion of pus in the cavity evidently continues, showing that some additional measures, such as those which may tend to secure perfect drainage, are still required.

Another instance is one of pneumo-thorax localized to the lower zone of the chest by adhesions of the lung. In this case constant cough, entirely preventing rest, night-sweats, elevated temperature, anorexia, and loss of flesh, were all marked. The gas treatment has been employed four weeks. The patient's condition has steadily improved, hectic and night-sweats and cough have ceased, and there has been a total gain of ten pounds. The patient takes daily exercise with freedom, and marked improvement in the pulmonary lesions can be recognized.

Finally, the most sadly diseased case of the group, a man forty-five years of age, five feet ten inches in height, with cavities in both lungs, profuse bronchial catarrh, and weight reduced to 100 pounds, the progress of the disease has apparently been arrested, and although the lesions are too advanced to make it possible for him *ever* to leave his bed, yet the relief of the distressing symptoms of fever, hectic, cough and expectoration, have certainly been manifest.

Summary.—1. In nearly all cases lasting effects have been secured in the reduction of temperature, suspension of night-sweats, lessened

cough, and expectoration, and in some, all physical signs of bronchial catarrh abolished.

2. Temporarily reduction of pulse-rate fifteen to twenty beats and temperature one-half a degree to one degree during the administration of the gas.

3. The amount of gas introduced into the bowel has varied from three quarts to a gallon at each injection. It has been introduced very slowly, from fifteen minutes to half an hour being demanded by the operation. The administration has been practised in most cases twice in the twenty-four hours. No injurious effects from the gas have as yet been observed.

4. Administration of the gas in different amounts and varying degrees of concentration is now being practiced, and also investigations into the characteristics of the sputa.

5. In only one of the cases of phthisis the effects of the gas have been entirely negative.

6. In cases of phthisis complicated by intestinal lesions, experience is still insufficient to make it possible to state positive results.

7. The ultimate value of the treatment can certainly only be established by time. The probable mode of action would seem to be antiseptic, and by reducing suppuration the relief of the attending serious symptoms, the patient is permitted to gain by food, exercise and general treatment. Thus far, the value of the gas seems to be that of a useful therapeutic measure, rather than a curative plan of treatment.

8. The method of preparing the gas for use in the hospital is as follows: The carbonic acid gas is passed through a solution of chloride of sodium and sulphide of sodium in twenty-two ounces of water. The proportion of the salts has been increased in some cases, and some trials of other combinations are being made.

HOW TO MAKE A POULTICE.—Dr. T. Lauder Brunton, editor of the *Practitioner*, makes the following remarks, and gives the following directions for making a poultice:

“In surgical cases we usually use the warmth and moisture of the poultice to act directly on the surface. We therefore make the poultice of crushed linseed or linseed meal and oil, spread it on some tow, and apply it to the skin without anything intervening. But useful though this method may be for wounds, ulcers, and abscesses, it is not the best form of application in cases of inflammation of the thoracic or abdominal viscera,

or when spasm is present without inflammation. In such cases we may, no doubt, do some good by applying the poultice to the surface exactly as in surgical diseases. We may draw off some of the blood to the surface; and we may also exercise a reflex action through the nerves upon the vessels of the inflamed organ below, but this will not be so great if we influence the surface only, as when we allow the heat to penetrate to the inflamed or irritated organs themselves. If we apply the poultice directly to the skin, it must be allowed to become tolerably cool before the patient can bear it, and thus half its advantage is lost. In order to relieve spasms, as in colic—intestinal, biliary or renal—to relieve inflammation of the pleura, the lungs, the liver or other organs—we want to apply the poultice as hot as possible, while we protect the skin from being scalded.

“In order to do this a flannel bag should be prepared, a convenient size being twelve inches by eight; this should be closed at three edges and open at the fourth; one side of it should be about one inch or one inch and a half longer than the other, and it is convenient also to have four tapes attached to the points which form the corners when the bag is closed, in order to keep the poultice in position. Besides this, another strip of flannel should be prepared of the same breadth as the length of the bag, and long enough to wrap around it once or oftener. Crushed linseed, bowl and spoon should then be got together, and the spoon and bowl thoroughly heated by means of boiling water; the poultice should then be made with perfectly boiling water, and rather soft. As soon as it is ready, it should be poured into the bag, previously warmed by holding it before the fire; the flap which is formed by the longest side of the bag should now be turned down and fastened in its place by a few long stitches with a needle and thread; it should then be quickly wrapped in the strip of flannel (also previously warmed), and fastened *in situ*, if necessary, by means of the tapes. It may be covered outside with a sheet of cotton wool. In this way the poultice may be applied ‘boiling hot to the skin without burning; the two layers of flannel which are at first dry allow the heat to pass very gradually indeed to the skin; as the moisture of the poultice soaks through them they become better conductors, and the heat passes more quickly, but the increase is so gradual as not to cause any painful sensation whatever, but only one of soothing comfort. The poultice also naturally keeps much longer hot, and the necessity for changing it arises much less frequently.

“The difference between the effect of a poultice made in the ordinary

way and in the manner just described is sometimes exceedingly striking. It is perhaps less marked in cases of inflammation than in those of spasm. We have seen a patient suffering from intense abdominal pain at once relieved by a poultice made in the way just described, although a succession of poultices made in the ordinary way had been utterly useless. This way of making poultices is one of the minutiae of medical practice, apparently extremely trivial, but really, we believe, very important. The relief which we have seen afforded by poultices made in this way, and the knowledge that *some* practitioners at least are ignorant of the method must be our apology for drawing attention to such a trivial detail."—*Quar. Compend.*

SOOTHING MIXTURE FOR CONSUMPTION.—Of all the mixtures for stimulating the consumptive patient, allaying his cough and quieting his nervousness, I have found none equal to the following :

R. Syrup liquorice root, ... ʒ j.
 Aromatic syrup rhubarb, ... ʒ ss.
 Fluid extract of opium, ... ʒ j.
 Liquor Ammon. acetat., ... ʒ v. M.

Sig.—Shake well. Dose—A tablespoonful every two or three hours.

Patients become very fond of this mixture, and it in no wise interferes with the stomach or appetite. Should constipation ensue, it is easily overcome by an occasional dose of comp. liquorice powder.—J. B. Johnson, M. D. in *Med. and Surg. Reporter*.

—As a *stomachic tonic* Prof. Bartholomew prescribed the following:—

R. Acid. phosphoric. dilut., ... f ʒ j.
 Strychninæ sulph., ... gr. j. M.

Sig.—Ten drops in water before meals.

—A case of *infantile eczema* of six months' duration was cured by Dr. Meigs in one week with the following:—

R. Unguent. zinci oxidi, ...
 Ung. petrolati, ... aa. ʒ ss.
 Hydrarg. chlorid. mitis, ... gr. x. M.

Sig.—Apply freely.

—*Col. and Clin. Record.*

SURGERY.

CHRONIC SERO-FIBRINOUS PLEURISY.—Dr. Benj. F. Westbrook, of New York, recommends (*New York Med. Jour.*) that a portion of one or more ribs be excised (Estlander's operation). Care is to be taken not to open the pleural cavity, and the wound is closed carefully to secure immediate union. Four or five days later the fluid is to be drawn off, through a large aspirator needle, when the chest wall will sink in towards the adherent lung. The operation is designed especially for old adults with unyielding ribs, where the lung is so bound down as to be unable to expand. He thinks that in a person beyond middle life, who has suffered for several months from a debilitating disease of this kind, the operation of resection of the ribs can be performed with a reasonable hope of obtaining primary union of the wound, and that the operation, if carefully performed, without wounding the internal periosteum or pleura, can be done without the fear of converting a serous into a suppurative inflammation.

THE TREATMENT OF BLENNORRHAGIC CYSTITIS.—(Dr. Desnos in *Bull. Gen. de Therap.*)

1. Blennorrhagic cystitis has its site in the cervical portion of the bladder; it is always associated with a deep urethritis, but the latter could not alone give rise to all the symptoms of cystitis present.

2. In the beginning of a blennorrhagia, certain patients experience frequent desire to micturate, which might be regarded as due to a cystitis, but the short duration of the symptoms present, and the absence of others pointing to cystitis, make the diagnosis clear.

3. In chronic cases, the diagnosis between blennorrhagic and tubercular cystitis is at times impossible when it succeeds an old gonorrheal inflammation.

4. A certain number of cases designated as cystalgia, neuralgia of the neck, are nothing more nor less than uncured cases of blennorrhagic cystitis. In certain cases, even after complete cure, a certain painful sensation persists for a very long time.

5. The treatment of acute cystitis by means of emollients seldom succeeds, and the disease persists. The neck of the bladder should be treated early, in the acute stage, by instillations of nitrate of silver. A sharp reaction occurs at the first application, but the amelioration is rapid.

6. In chronic cases, washing out the bladder is a measure of little

worth, and can bring back the disease to its acute stage. General treatment is an excellent adjuvant to local treatment, which is indispensable.

7. This local treatment should consist in instillation of substances against the neck, which will modify the disease.

8. Corrosive sublimate, in the strength of from 1:250 to 1:500, produces severe pain, which continues for a long time, and its effects are slower than those of nitrate of silver.

9. Iodoform dissolved in oil, or suspended in glycerine, can be applied without causing pain, but its effects though satisfactory, appear slow and uncertain.

10. The hydrochlorate of cocaine relieves the painful conditions of the bladder for a short period of time only, but applied about the neck of the bladder before the instillation of a caustic, it modifies materially the pain.

11. From all points of view, nitrate of silver possesses an incontestable superiority over other therapeutic agents.—*Journal of Cut. and Ven. Dis.*

THE MEANS OF TOPOGRAPHICAL DIAGNOSIS OF FOCAL DISEASE AFFECTING THE SO CALLED MOTOR REGION OF THE CEREBRAL CORTEX.—The necessity for exact knowledge of the relations between the external surface of the head and the various encephalic regions has arisen so rapidly within the last few years as to force each practical surgeon to work out the required facts for himself with the aid of the few papers that have appeared on the subject. Owing to the absence of any comprehensive monograph giving a complete directory, as it were, of these parts of the brain whose function is so far understood as to admit of the localization of lesions within their boundaries, Mr. Victor Horsey has presented in the April number of *The American Journal of the Medical Sciences*, for the use of those who may be called upon to explore the cranial cavity, a summary of the means adopted by himself as topographical guides to definite portions of the brain, which have so far, in his experience, fortunately been equal to the exigencies of ten cases submitted to operation.

The localization of disease of the encephalon is obviously a two-sided process. First, the diagnosis of the seat of the disease in the nerve tissue, by observation of the symptomatic perversion of function; and, secondly, the determination of the particular part of the skull and soft parts covering the focus of disease. The second part of the process has usually been separated from the first, and considered by itself, under the title of cerebral topography, and may, doubtless, with advantage be thus studied

as a distinct subject; but it really is in closer connection with the other division, namely, cerebral localization, than may appear at first sight to the anatomist.

Mr. Horseley points out that the localities in which different functions are represented are not separated by hard outlines (and this belief is also borne out by experiment), but that they occupy absolutely constant focal positions, and in this way will in the immediate future be very accurately mapped out.

The topographical relations of the so-called motor region to the exterior of the skull are lucidly explained, and then he presents an enumeration and limitation of the areas of representation of the different parts of the body in the gyri thus topographically determined. The text is fully elucidated by numerous diagrams.

GLEET.—Bumstead relates that Ricord used to say to his students: "Gentlemen, if I am to go to—well—the bad place, I know what my punishment will be. I shall have a lot of fellows with the gleet standing round me with their lamentations, their importunities, and their prayers to make them well." Bumstead adds: "This *mauvais mot* but faintly indicates the annoyance which a case of gleet often gives both to patient and surgeon."

A PRACTICAL SURGICAL HINT.—Dr. John F. Lockwood writes to the *Med. Record* that a young man came into his office, having severed the radial artery in the wrist. He was unable to find the bleeding points readily, because of the constant oozing of blood which obscured the field of operation, and sponging was of little avail. It then occurred to him to blow away the blood, which he did, and found that by this means he could keep the wound so free that the ends of the arteries were readily found and tied.

TREATMENT OF ANAL FISTULA IN PHTHISICAL PATIENTS.—Dr. Glover summarizes as follows; Operative interference is practiced with benefit excepting, first, where the cough is constant, unless this be first allayed; second, where the pulmonary disease is rapidly advancing or is far advanced; third, where the reparative powers of the patient are so low that they evidently are unequal to the task of healing the wound. Although it is proper to operate during any season, preference should be given to pleasant weather, such as will allow the patient to be in the open air. Where the tissue surrounding the fistulous tract is supposed to be tubercular, some advise its removal by the knife or sharp spoon. The

wound heals in nearly every case in which the operation is justifiable. There should be as little interference with the sphincter muscles as possible. The suppression of the discharge is thought to be positively beneficial. It is recommended by some that where the discharge is supposed to have a beneficial derivative effect, a seton be inserted in the arm or other eligible part, before operating on the fistula. It is believed that a successful operation tends to retard the progress of the phthisis and to prolong the life of the patient. There are many cases in which this question presents itself as a subject of vital importance and one upon which all the experience of the profession should be thrown, that the disputed points may be cleared up and the method of treatment placed upon a clearly defined basis.

DEATHS FROM EAR DISEASE.—Dr. Ariza, writing in *El Dictamen*, asserts that every person who has had suppurative otitis media, dating from infancy, dies from the consequences of this affection before or during early adult life. Death in these cases results from caries, pyemia, thrombosis of the cranial sinuses, meningitis, encephalitis, or abscess of the brain.—*N. Y. Med. Record*.

THE "GELATIN BANDAGE."—As a substitute for those greasy abominations—ointments—in all kinds of skin diseases where you desire to see the part affected and still cover it from the air or protect it from the touch of the clothes, and yet have it easily removed, the gelatin bandage is vastly in advance of the ointment. They (the ointments) are dirty; they stain the clothes; they cannot be permanently applied without bandages, and even then the cloth will absorb them; they are hard to wash off, and there are many other objections to their use, in a large number of cases. Now, to meet all these objections I must submit the gelatine bandage, as used in Prague with so much success. It is not a bandage; it consists of pure gelatin to twice as much distilled water. After heating it add whatever you wish—crysarobin, oxide of zinc, carbolic acid, salicylic, boric, iodoform—whatever you wish—then apply with a soft brush or feather (I use my finger); and as it is drying, run your finger over it with glycerine, a thin coating, to keep it from cracking. It is splendid for psoriasis, and completely hides the stains of chrysophanic acid.

A slight modification of this has long been used for burns and scalds and fresh injuries in New York hospitals—white glue, one half pound; glycerine, one ounce; carbolic acid, two drachms, and boiling water, one pint. Keep in a close capped jar and heat the quantity you require ready

in your office, and you will find it an excellent application. It is a decided improvement on the abominable linseed oil and limewater.

Time does not permit me to go thoroughly into the uses of this gelatin bandage, or I am sure you would think it better than anything you have heretofore used in its particular range of application.—J. E. White, M. D., in the *Canadian Practitioner*.—*Technics*.

THE PROPER POSITION AT WHICH TO OPEN A FELON.—In opening a felon, the parts to be avoided are lines of the arteries and that of the flexor tendon, which is the median line. The felon should be opened midway between the artery and the tendon. If necessary, it can be opened on both sides. If the sheath of the tendon is opened, the tendon will almost always slough, and the finger will be useless.—John Ashhurst, Jr. in *Polyclinic*.

FEEDING AFTER SURGICAL OPERATIONS.—Dr. Jas. B. Hunter, of New York, holds that the surgeon should not consider his responsibilities at an end with the performance of a given operation, but should extend his care and supervision to all the details of the after-treatment, the first and chief of which is the proper nourishment of the patient until convalescence is established. The points emphasized by the author (*Medical Record*) are these :

1. That personal attention should be given, with precise directions, to the nourishment of patient after all surgical operations, and that too much should not be entrusted to nurses, who can have no means of knowing the varying requirements of individual cases.
 2. That vomiting is to be avoided by every means in our power, even if it require absolute rest of the stomach for several days.
 3. That even appropriate food, where it can be borne, should be given in very small quantities, and at regular intervals.
 4. That systematic nourishment by the rectum should be resorted to promptly if other means fail or are insufficient.
 5. That less food and more water should be given if the patient suffer from fever.
 6. That the dangers caused by vomiting, by flatulence, or by food difficult of digestion, are much more to be dreaded than those due to abstinence from food.
 7. That stimulants are of great value, where needed, to meet special indications, but may be generally discontinued as soon as food can be digested.
- It will be found, as a rule, Dr. Hunter states, that after prolonged anesthesia the stomach is proportionately longer in recovering its tone. It is held that, when the stomach continues to reject food, systematic rectal alimentation should be resorted to after the second day.

Dr. Hunter has not much faith in milk in this form of nourishment, but prefers some preparation of beef, such as strong peptonized beef-tea, beef peptonoids, and especially, in critical cases in which nourishment by the rectum is the chief dependence, a mixture of pulp made by scraping raw beef with half of its bulk of pancreatic emulsion. This mixture is allowed to stand in water considerably below the boiling-point until it liquifies and assumes an homogeneous chocolate-like appearance. Two fluid ounces of this mixture should be administered not more frequently than every four or five hours,—*Med. Age.*

TRANSPLANTATION BY EXCHANGE.—Mr. C. B. Keetly reports in the *Lancet*, a case of a large hairy mole covering nearly the entire cheek of a young infant. If he removed it *en masse*, leaving the wound to heal by granulation, the resulting scar would be nearly as great a deformity as the mole. If he took a flap from the arm, to cover the surface, the wound in the arm would likely prove disastrously large. He raised the mole as a flap, made a corresponding flap on the arm, brought the arm in juxtaposition to the head and fastened it there by plaster of Paris, attached the arm flap to the face and the mole flap to the arm, waited a few days until union of each had taken place, and then completed the operation by severing the pedicle of each flap. The result was excellent.

THE TONIC TREATMENT OF THE HAIR.—(Dr. Foley, in *New York Medical Journal*.)—A wineglassful of aromatic spirits of ammonia added to a basinful of water is very cleansing and refreshing. Care should be taken that it does not get into the eyes. The shampoo as given by the barber is too rough and vigorous, and the conglomeration he puts on the head afterward is anything but beneficial. While one performs daily ablutions of the face, hands, and body, the head is generally left out. This should not be; it is as necessary to wash the scalp as any other portion of the body. The hair should be brushed daily. Too much violence must be guarded against. It should be brushed gently in the direction in which it lies. A harsh brush should be used to cleanse the scalp of dust and dandruff, and then the hair-shafts should be smoothed and polished by means of a softer brush. The scalp should receive a roseate glow. This insures quicker circulation in the follicle about the hair-papilla, and hence the growth is invigorated. Hair-tonics have the same effect upon the skin—viz., a stimulating effect upon the skin capillaries. Morning and night, before retiring, is the best time for brushing the hair. Too hard brushing tends to produce dandruff. In brushing, the object is to

cleanse it from extraneous materials, such as feathers, dust, dandruff, and concrete sebaceous material, which often oozes out upon the scalp, to make it smooth, and to bring truant hairs into the right place, and set at harmony discordant filaments.

Friction polishes the hair as well as bandoline or ointment. The end we seek in building up a scanty hair crop is a proper amount of blood-supply, through friction and hair tonics. The appended is an excellent hair-tonic :

R. Acid. carbolic..... $\bar{3}$ ss.
 Tr. nucis vom..... $\bar{3}$ ij.
 Tr. cinchonæ rubr..... $\bar{3}$ j.
 Tr. cantharides $\bar{3}$ ss.
 Aq. cologniensis } aa q. s. ad $\bar{3}$ iv. M.
 Ol. cocois }

Apply once or twice a day to the scalp by means of a soft sponge. This will prevent the hair from falling out if it does not produce a luxuriant crop.

COLUMBUS MEDICAL JOURNAL.

EDITORIAL.

HEALTH vs. HEATING AND VENTILATION.

The heating and ventilation of our houses has so much to do with the health and comfort of the inmates that it surprises us that it receives so little attention. With the proper appliances used, the vitiated or foul air is removed, and a supply of fresh admitted, but when such precaution is ignored, the germs of disease gain an easy foothold, and scarlet fever, diphtheria, and other kindred maladies assume a malignant type. Parties building would do well to dispense if necessary with some extravagant ornamentation, and supply their homes with a good hot-water heating apparatus, such as that brought out by Mr. Samuel D. Tompkins, engineer, and manufactured by the A. A. Griffing Iron Co., 518 Communipaw ave., Jersey City, N. J., which meets all the conditions required; *i. e.*, cheapness, durability and effectiveness; the latter, however, being the most prominent. On application the A. A. Griffing Iron Co. will send their handsome illustrated circulars, both of hot water heating and ventilating apparatus, and their numerous constructions for steam uses, and those who may be building, or about to build, would do well to consult the above firm before purchasing heating appliances.

Fluid Forms of Hydrastis.

The reputation of this drug as a therapeutic agent was first gained through its employment in the form of an *infusion*; and in the fifty years following its introduction into medical practice, a continuous effort has been made by manufacturers to perfect a preparation which would represent all the active principles of the drug, without the high price of the salts, either alone or in combination.

The most prejudiced writers on *Materia Medica*, accord to the late Wm. S. Merrell the largest share of credit in the introduction of Hydrastis preparations, and to the present organization the reputation of being the *largest consumers of the drug in the world*. For more than a half-century, Hydrastis has been made a study in our laboratory, and we do not think we exaggerate its importance when we assert that it stands pre-eminent to-day as the most valuable exponent of our vegetable *Materia Medica*.

The following preparations in *fluid form* are receiving our special attention at this time:

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Is what its name implies—the active, medicinal principles of the drug in natural combination and in a fluid form. It has a bright, yellow color, perfectly clear, free from sediment, and with an unmistakable odor of the *fresh drug*.

Fluid Hydrastis is a pure, neutral solution of all the alkaloidal constituents of the drug, rejecting the oil, gums, irritating and offensive resins and inert extractive matters. The success attending its introduction is the best evidence of its therapeutic value.

Unsuccessful imitations and would-be substitutes are met with on every hand. Preparations said to be “just as good” or “about the same thing,” but always “a little cheaper,” attest the wide-spread and growing popularity of Fluid Hydrastis. All such, compared with the latter as to physical appearance or as representatives of the drug, *are condemned*; dispensed in prescriptions, *they are readily detected*; tested therapeutically, they are *promptly rejected* as unworthy of confidence.

Fluid Hydrastis is applicable to the treatment of all irritable, inflammatory and ulcerative conditions of the mucous tract.

This statement of a well-known medical writer and journalist has become axiomatic:

“No remedy for physician's use has been received with such universal approval.”

Solution Bismuth and Hydrastia—MERRELL.

An invaluable and scientific combination, wherein the beneficial action of the white alkaloid is increased by association with Bismuth. This solution contains $2\frac{1}{2}$ grains of the double Citrate Bismuth and Hydrastia; twenty-five per cent. of which is Hydrastia Citrate.

The cordial reception accorded this preparation marks it as the most valuable combination in the market in which the white alkaloid alone represents the valuable properties of the drug. Used in diseases of the nasal passages, of the eye, of the throat, of the stomach and intestines, of the reproductive organs and bladder it is equally beneficial.

Colorless Solution of Hydrastia—MERRELL.

This is a permanent solution of the white alkaloid, without the addition of any other medicinal agent to modify or increase its action. It is offered without special recommendation to meet the views of an unlimited number of physicians, with whom the color of the Fluid Hydrastis is an objection. This solution contains in one fluid pint the same proportionate strength of white alkaloid as exists in an average quality of crude root.

See notes above on Solution Bismuth and Hydrastia.

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HANN & ADAIR, Publishers, Columbus, O.

THE TREATMENT OF CONSUMPTION BY GASEOUS ENEMATA.—It is now about four years since Dr. L. Bergeon, lately Professor in the Medical School of Lyons, commenced experiments in the treatment of pulmonary consumption, by rectal injections of sulphuretted hydrogen and carbonic acid gas. His results, and those of others who have been working in the same field, have lately been published. We re-produce, in this issue, an article showing the results obtained in one of the Philadelphia Hospitals.

"The principle upon which the treatment is based is that the disastrous results of pulmonary tuberculosis are due to septicemia set up by absorption of the noxious products of suppuration in ulcerous lesions in contact with the atmospheric air; and that repeated prolonged bathings of the suppurating surfaces with a safe antiseptic agent, controls the suppuration and gives the lesions an opportunity to undergo cicatrization. When an attempt is made to administer such an agent by inhalation, the quantity required to produce the desired effect is so large that it is poisonous to the individual. The same may be said of administrations by the stomach, or by the subcutaneous connective tissue. Dr. Bergeon, reasoning on some experiments reported by Claude Bernard in 1857, has found that certain antiseptic agents (hydrogen sulphide the best) can be administered in sufficient quantities by the rectum with impunity, provided care is taken not to introduce too much at a time. Claude Bernard demonstrated that when a toxic or medicinal agent is introduced into an organ at a distance from the arterial system—the digestive tube, for example—it could not penetrate into the arterial system because it becomes eliminated before it can reach that system. It has to traverse the portal system, the liver, the hepatic veins, and the pulmonary tissue; during which transit it may be eliminated in the liver by the bile, or, if volatile, in the lungs by exhalation."

A mixture of carbonic acid gas and sulphuretted hydrogen is thor-

oughly tolerated by the bowel when the gases are pure. The carbonic acid gas is inert except that it attenuates the irritant properties of the hydrogen sulphide, is likewise rapidly absorbed by the venous system, and rapidly eliminated by the lungs, while its anesthetic properties may have some influence in preventing colic of the intestine in the introduction of the hydrogen and in subduing irritation in the pulmonary tract in its elimination.

Dr. Morel's apparatus for generating the carbon dioxide consists of a bottle in which three tablespoonfuls of sodium bicarbonate are placed. The bottle is then closed by a cork having two apertures, through one of which passes a glass tube to the bottom of the bottle, the upper portion being expanded into a funnel-shaped reservoir for the dilute sulphuric acid, beneath which is a glass stop-cock to regulate the descent of the liquid. (Instead of this an ordinary "safety tube" can be used.) The second aperture in the cork is filled with a curved glass tube for the escape of the gas. This tube is attached by rubber tubing to a rubber bag of six litres capacity, in which the carbonic acid gas is to be stored. The mouth of this bag may for convenience be furnished with a stop-cock. (A beef's bladder will answer as well.) The sodium bicarbonate being placed in the bottle, the cork is inserted, and a small quantity of the dilute acid introduced. Carbonic acid gas is evolved immediately. A little gas is allowed to escape into the atmosphere, so as to drive off the atmospheric air in the bottle, and the reservoir is rolled tightly so as to drive out all the air it contains. The reservoir is then connected with the bottle and allowed to fill with the gas. It is then removed and its stopcock closed.

The gas is now ready for use. The reservoir is attached to a hand-ball aspirator with check valves at each end (or to the lower tube of any ordinary bulb syringe). The exit tube of the aspirator (or syringe) is then attached to a tube which passes through a cork into a bottle nearly filled with the medicated solution, preferably a highly charged natural sulphur water. The portion of the tube which projects through the cork must reach the bottom of this bottle, so that the gas as it is forced through may bubble up through the water and become thoroughly impregnated with the sulphur. An exit tube is also passed through the cork and is connected by several feet of rubber tubing with an ordinary syringe nozzle for introduction into the rectum. The aspirator is worked two or three times to drive out the air in the bottle, a point to which the physician must direct the attention of the nurse. The nozzle is then inserted into the rectum of the recumbent patient and the injection made slowly. All

clothing must be loose. With the hand on the abdomen, the amount of distension of the colon is noted, and when this is marked, or when pain is complained of, the process is suspended until absorption takes place, as manifested by relaxation of the tension; and then the process is resumed. Fifteen to twenty minutes are consumed in driving the six quarts of carbon dioxide through the sulphur water into the bowel.

It is well to have a bed-pan at hand as there may be a call to stool. The injection should not be made upon the full stomach, as this may produce emesis. Three or four hours after a meal is the best time for injection. Two injections are given daily. At the first injections a smaller amount of gas should be used, so that the patient may be gradually accustomed to the process.

But a curious feature of all this is that it is not new! Priestly alludes to the use of carbonic acid gas by inhalation in the treatment of phthisis, and Percival (1768) even proposed its administration by rectal injection.

Whatever may be the value of the treatment, its merit does not consist in the power to destroy the bacillus tuberculosis, or bacteria. This point has been settled definitely. A large quantity of the combined gases has been forced through a small volume of a pure culture of the bacillus, and the culture has shown no evidence of any loss of vitality or of infective power.

We are now using this method on a case of advanced tubercular phthisis. The apparent results are so far gratifying. But we are not sanguine; we do not believe that the treatment will accomplish any marvellous change in the mortality of the disease. Reports giving the dark side will soon come in, if we mistake not, and the apparatus will be relegated to the well-filled closet of wrecked hopes.

It certainly was not the erudite editor of the *Journal of the American Medical Association*, but some callow youth about the office, who wrote in a recent editorial on this method; "Every practitioner [is] guilty of negligence toward his patients if he does not try the method in suitable cases."

THE main features of the law regulating the practice of medicine in Minnesota recently enacted are:

1. The appointment of a Board of Examiners by the Governor.
2. No member can serve to exceed two terms in succession.
3. Two members are to be homeopaths.
4. All persons hereafter commencing the practice of medicine in the state must pass an examination upon the

different branches. 5. Before entering upon said examination they must produce evidence of having attended three courses of lectures, if date of diploma is later than 1887. 6. Power is given the board to refuse or revoke license for unprofessional, dishonorable, or immoral conduct. 7. No member of any existing medical faculty eligible to appointment upon new board.

The last section is an especially satisfactory one, since it divorces entirely the licensing from the teaching power.

This is what is needed in every state in the Union. Medical colleges should be permitted only to sell medical information, and not the right to practice medicine. The State itself should determine whether the purchaser of medical knowledge has received his goods, and is able to utilize them, and not permit the college which sold them to decide the matter.—*Weekly Med. Rev.*

THE magnificent new building of the medical department of the Western Reserve University, Cleveland, O., was dedicated Tuesday, March 8, 1887. This was a red letter day in the history of this institution, which now enjoys the distinction of possessing one of the finest, if not the finest, medical college buildings in the United States.

The building cost \$175,000. The ground dimensions are 82x134 feet, four stories high with a basement. It is built of Twinsburg brown stone, the Romanesque style of architecture. It contains two amphitheaters, one seating 240, to be devoted to clinical instructions, the other seating 500 students. The chemical lecture room is 32x54 feet, and, like the amphitheaters, is furnished with opera chairs. The clinical rooms, dispensary, dissecting, reading, faculty and cloak rooms and laboratories are all large, admirably arranged and perfectly adapted to their special purpose. The lighting of the building by glass roof and ceilings is unsurpassed. The building is heated by steam apparatus, and supplied by fans with hot and cold air.

A STEP IN THE REFORM OF ENGLISH SPELLING.—Professor Skeat, in a recent number of *Notes and Queries*, says: "Those who know the whole history of our spelling from the eighth century to the present time best understand the harm done by the pernicious system of trying to transplant Latin and Greek symbols into the English language. The symbols *æ* and *œ* are not English and are best avoided. Indeed, this is done in practice when once a word becomes common. *Æther* and *ætherial* have been sensibly replaced by *ether* and *etherial*. No one now writes *æternal*. *Solecism* is now *solecism*, and I trust *primeval* and *medieval* will soon prevail over *primæval* and *mediæval*. Pedantic spellings are most objectionable,

because they are useless and unphonetic." We heartily agree with Professor Skeat, and trust that *diarrhæa*, *leucorrhœa*, *dysmenorrhœa*, etc., will soon give place to *diarrhea*, *leucorrhœa*, *dysmenorrhœa*, etc.

The above is from the *British Medical Journal*. To be consistent, however, the *Journal* must also use *edema*, *fetus*, *cesarean*, etc. The characters α and ω are not English, and should not be tolerated in anglicized words. They have long since been so forbidden in the composing room of this JOURNAL, and, in this country at least, they are rapidly falling into innocuous desuetude.

GEN. FRANCIS A. WALKER does not share in the anxiety which finds pretty free expression in the scientific and literary quarters, touching the spread of socialistic ideas. In an article to be published in the *Forum* for May he draws a clear line of distinction between "the socialists" the terrible fire-eaters who would wreck, pillage, and destroy all civilization, and who are simply to be treated with the club or the strait-jacket, or on occasion with the rope; and the advocates of a form of government more or less socialistic, men who believe that a government is best employed in promoting, in every fair and feasible way, the good of the governed.

THE Lambert Pharmacal Co., of St Louis, have just issued a large pamphlet on Listerine. It contains many practical hints on the use of this valuable remedy. It can be obtained free of cost upon application. Write for it.

THE attention of physicians is called to the new, elegant and scientific preparation of Hypophosphites prepared by Rukard Hurd, Chemist. It is clear and clean, and does not precipitate nor vary in any way, so that the patient receives the true dose every time. It relies on its merits as a strictly first class article. Sample bottle mailed free.

"METRITIC WOMB"—When a Columbus physician, several years ago, spoke of a case he had of "hepatized liver," we all smiled. Now, however, a Chicago doctor (*Chicago Med. Jour. and Examiner*, Feb. '87.) tells us that a "*metritic womb*" is not more important or serious than a carcinomatous one."

MARRIED.—At the residence of the bride, April 21, 1887, Dr. Charles R. Vanderburg, of Columbus, and Miss Elsie Briggs, of Franklin Tp. At home at 64 East Rich St.

DR. Chas. P. King pays a glowing and worthy tribute to the memory of the late Dr. J. W. Russell, in the *Newark American* of March 28th.

WE have received from Messrs. Parke, Davis & Co. a fine lithographed portrait of the eminent Dr. Robert Koch, of Berlin. They desire us to state that they will mail free of charge, a copy of the picture to any of our professional readers upon a receipt of request.

DR. WM. MORROW BEACH.—Just as we go to press the daily papers announce the serious illness, and anticipated death, of Dr. Wm. Morrow Beach, of London, Ohio, ex-President of the Ohio State Medical Society, and also of the State Sanitary Association.

FOR SALE—A good paying practice, with office, dwelling, barn, out-houses, etc., in one of the best counties in Illinois. No opposition. Two railroads. \$650 buys the whole thing, as I want to go west. A rare chance. Those who mean business address or call on me immediately. G. F. ENGLISH, M. D., Isabel, Edgar Co., Illinois.

REVIEWS AND BOOK NOTICES.

Common errors; Theroretical and Practical, Relating to Insanity. By Orpheus Everts, M. D., Medical Superintendent to the Cincinnati Sanitarium.

He regards insanity as a disease of the brain rather than of an immaterial, hence hypothetical, entity called "the Mind," the latter idea being but a survival from the mythopoetic concepts of primitive peoples, born of efforts to solve the riddles of the universe without the capability of nature, growth, or the knowledge of facts acquired by experience. An etiological error is that of ascribing insanity to a single cause, such as intemperance, overwork, remorse and the like, the fact being that most cases are the result of a conspiracy of causes more or less complicated, heredity playing an important part. Another common error is that of mistaking symptoms for causes of the disorder, a case in which the prominent feature is of a religious character, usually being reported as caused by "religious excitement;" or if onanism be present, as "masturbational insanity." And so he goes on to point out errors of diagnosis, prognosis,

treatment, classification, etc. He thinks (in common with all who have given attention to the subject) that the greatest therapeutical error of practice is that of administering too much medicine (which might be very properly be extended to cover the treatment of nearly all diseases).

A Practical Treatise on Obstetrics. Vol. I. (4 vols.), Anatomy of the Internal and External Genitals, Physiological Phenomena (Menstruation and Fecundation). Vol. II., Pathology of Pregnancy. By A. Charpentier, M. D., Paris. Illustrated with lithographic plates and wood engravings. These are also Vols. I. and II. of the "*Cyclopedia of Obstetrics and Gynecology*" (12 vols.), issued monthly during 1837. New York: William Wood & Company.

The author is head of the obstetric clinic at the School of Medicine, Paris, and adjunct to the chairs of Obstetrics of Professors Pajot and Depaul. His work on Obstetrics may be regarded as the most complete in any language, and as a faithful and unbiased mirror of the theories and of the practice of the most renowned obstetricians of the world. In the few years which have elapsed since its publication, there are certain topics wherein both practice and opinion have somewhat altered, and there are others which have become settled on a firmer basis than was then the case. The editor has aimed to express these changes, and to add the requisite new matter, thus in every respect bringing the work up to date. He has also, here and there, criticised such methods as have seemed to him not completely in accord with the opinion of the authorities on this side of the Atlantic. These additions and notes have necessitated slight condensation in the text, and the omission of a number of statistical tables, but nothing of the kind has been done at the expense of the author's thought, or of the value of the work as one of reference. New illustrations have been substituted, and added, wherever it seemed appropriate. The section on Embryology, in Charpentier's treatise, has been omitted, and in its place has been substituted the admirable chapter which Professor Milnes Marshall contributed to Barnes's System of Obstetric Medicine and Surgery.

Manual of Operative Surgery. By Joseph D. Bryant, M. D., Professor of Anatomy and Clinical Surgery, and Associate Professor of Orthopedic Surgery, Bellevue Hospital Medical College, etc. With about 800 Illustrations. New York: D. Appleton & Co. 1887. Cloth. 8vo., pp. 530.

This work is the outcome chiefly of the author's experience in the field of operative surgery. His official positions have supplied him with abundant material for his purpose, while his own judgment and surgical

REVIEWS AND BOOK NOTICES.

has enabled him to produce a most excellent work for the benefit of student and practitioner. The various operations of the day are

included. The operations on the eye, the ear, and the female genital organs have been omitted as being too complex for this work. The illustrations are numerous and excellent. A careful examination of the pages convince one that it is a thoroughly good book such as should be in the hands of every general practitioner.

Diseases and Their Diagnosis. A Treatise Upon the Phenomena Produced by Diseases of the Nervous System, with Especial Reference to the Recognition of Their Causes. By H. C. Wood, M. D., D. Member of the National Academy of Sciences. Philadelphia: J. B. Lippincott & Co. 1887. Cloth. 8vo, pp. 501.

The object of the author in this work is what he calls "diagnostic logic." He studies especially the phenomena of nervous diseases so far as they bear upon the recognition of those diseases; he does not concern himself with the details of treatment. Beginning with the different forms of paralysis, he passes to motor and then to sensory symptoms, and ends with a discussion of those interfering with memory, consciousness and intellection. Such a scheme is strictly symptomatic and neglects the practical advantages of symptomatic schemes in general although it seems to possess less scientific precision.

The subject is worked up from an ample clinical experience and from a reading of special literature. The book cannot fail to interest all who care for the study of nervous diseases or their phenomena.

Medical, Pharmacy and Therapeutics, including the Physiological Action of Drugs, Special Therapeutics, Official and Extemporaneous Pharmacy, with numerous Tables, Formulæ, Notes on Temperature, Clinical Thermometry, poisons, Urinary examinations and Patent Medicines. By Samuel O. L. Potter, M. A., M. D., Professor of Practice of Medicine, Cooper Medical College, San Francisco. P. Blakiston, Son & Co., 1887. 8vo. pp. 828. Cloth, \$3.00. Columbus: A. H. Smythe.

The author is already known for his compends which have been received with much favor. His present effort is on a larger scale, and will we hope meet with commensurate success.

In detailing the physiological action of a leading drug, its characteristic qualities are first enumerated, then its action in an ordinary medicinal dose, next the effects produced by small doses continued, and finally those

from a toxic dose ; these being followed by a brief account of its antagonists and incompatibles, and a concise view of its therapeutical applications. Throughout the work the utmost brevity of language is employed consistent with the retention of all the essentials of the subject. Every drug and preparation official in the last edition of the U. S. Pharmacopeia is noticed fully, while all prominent unofficial drugs receive such mention as their respective importance demands.

The portion of the book devoted to pharmacy has been written with especial reference to the belief that many young practitioners would dispense their own medicines if they had any practical directions on the subject. *Perscription writing* receives full consideration, and samples are given for prescriptions of each class in extemporaneous use.

Special Therapeutics are treated elaborately in the third part, which is an *Index* to the treatment of disease as laid down by the modern writers.

The appendix contains numerous *Tables* comprising doses, diagnostics, Latin terms, formulæ for hypodermics, metric equivalents, specific gravities and volumes, and obstetric memoranda—together with *Notes* on temperature and the clinical thermometer, poisons, urinary examinations and patent medicines.

Granular Lids and Contagious Diseases of the Eye. By W. F. Mintendorf, M. D., Ophthalmic Surgeon to the New York Eye and Ear infirmary, etc. Pages, 110. The Physician's Leisure Library. Detroit: George S. Davis. 1886.

The importance of a prompt diagnosis of contagious diseases of the eye is self-evident. Our blind asylums are filled with those whose blindness is due to such diseases. This book aims to supply to physicians the means of an early diagnosis of these cases with directions for their proper treatment. It should be widely and carefully read.

Diseases of Women ; A Handbook for Physicians and Students. By Dr. F. Winckel, Professor of Gynecology and Director of the Royal University Clinic for Women in Munich. Authorized translation by J. H. Williamson, M. D., Resident Physician Allegheny General Hospital, Allegheny, Pennsylvania. Under the supervision and with an introduction by Theophilus Parvin, M. D., Professor of Obstetrics and Diseases of Women and Children in Jefferson Medical College, Philadelphia: P. Blakiston, Son and Co. Columbus: A. H. Smythe. 8vo. pp. 674, cloth \$3.00.

Dr. Winckel is already quite well known to American physicians through his work on the pathology and treatment of child-bed, translated by Dr. Chadwick some ten years ago. In the work before us he takes up

the non-puerperal diseases of women, with the exception of urinary fistulæ which he treats of in a separate book.

The chief features of the present volume are the very practical classification of diseases according to their anatomico-pathological basis; the numerous literary references; the number of affections not usually considered in gynecological works, which are here described; and, finally, the conservatism which marks its therapeutics. The illustrations are numerous and generally original, and excellently engraved. The author is strongly opposed to the present fashionable craze for removing the ovaries.

Dr. Parvin's introduction is an excellent summary of views on questions of procedure which are still *sub-judice*.

Wear and Tear, or Hints for the Overworked, by S. Weir Mitchell, M. D., LL. D., Harv. Member of the National Academy of Sciences; President of the College of Physicians of Philadelphia, etc. Fifth edition, thoroughly revised. Philadelphia: J. B. Lippincott Company, 1887. 12mo. Cloth. pp. 76. Price \$1.00.

Dr. Mitchell defines *Wear* as the "natural and legitimate result of lawful use, and is what we all have to put up with as the result of years of activity of brain and body. *Tear* is another matter: it comes of hard or evil use of body or engine, of putting things to wrong purposes, using a chisel for a screw-driver, a penknife for a gimlet. Long strain, or the sudden demand of strength from weakness, causes tear. Wear comes of use; tear of abuse."

For years he has been preaching the gospel of physical culture and prudence, and his words have not fallen on unheeding ears. The present volume is in the line of that preaching, and should be widely read.

On the Determination of the Necessity for Wearing Glasses. By D. B. St. John Roosa, M. D. Pages, 73. Leisure Library. Detroit: George S. Davis. 1887.

This little book is designed to serve as a guide to the general practitioner in determining whether a patient requires glasses, either to secure more perfect vision to relieve or a symptom due to some error of refraction. The name of its distinguished author is a sufficient guarantee of its scientific and practical value.

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COMMUNICATIONS.

THE DIAGNOSIS AND TREATMENT OF CHRONIC DEAFNESS.

BY S. L. MCCURDY, M. D., DENNISON, OHIO.

Surgeon to P. C. & St. L. and C. L. & W. Ry's, Member of American
Medical Association, etc.

(Read before the Stillwater Medical Society April 5th 1887.)

On Feb. 28th Ed. Clark, aged 15, came to my office, and was found, on examination, to be quite deaf. I learned that when he was five years of age, he had scarlatina and was left with this physical deformity after recovering from this disease. It was only with a great effort that he could be made to understand intelligently articulate language. He was taken to the dark room and on examination with head mirror and Grueber's speculum, it was found that both drums were imperforate, with no perceptible signs of cicatrices, which if present would have indicated a chronic or old otitis media purulenta. The "cone of light" with its base toward the lower and anterior part of the membrane, and its apex pointing upward and backward toward the handle of the malleus, was distinct, as was also the handle of the latter bone, both showing with the usual lustre.

The relative position, form, size, inclination, degree of transparency and texture, were apparently normal in both ears. The lustre was not

quite as bright, possibly, of the left membrane as the neutral gray of the normal. The convexity of the left membrana tympani was very slightly increased, which change in curvature would account for the slight alteration in lustre referred to above. In short, the general appearance of both membranes and external auditory canals did not explain the cause of the patient's deafness. I then made examination for hearing distance. It has been determined by examining normal ears in numbers that the average distance such an ear can hear an ordinary watch with distinctness is 40 inches. The fraction that represents a normal ear is then $\frac{1}{40}$. Defect of hearing is expressed with the hearing distance found in a given case for the numerator and the normal distance for the denominator. For instance, if the hearing distance is found to be 8 in. it would be represented in this way, H. D. R. E. $\frac{8}{40}$; and in the opposite ear 11 in. it would be represented in the following way $\frac{11}{40}$. H. D. R. E. is hearing distance of right ear, and H. D. L. E. means of the left ear. In the case under consideration it was found to be $\frac{6}{40}$, or contact; that is, the watch could only be heard by placing it in contact with the helix. Both ears were found to be $\frac{6}{40}$. When the watch cannot be heard except by firmly pressing it against the ear, it is $\frac{0}{40}$, or if hearing is absent it is $\frac{0}{40}$.

To further inquire into the cause of deafness it is customary to next examine as to disease of the acoustic nerve. This is done now very satisfactorily by using a tuning fork made especially for the purpose. I think it was introduced by Prof. D. B. St. John Roosa, of New York. Prof. Roosa prefers a large sized fork with tone C. In the normal ear the fork is heard much better through the air than when placed in contact with some portion of the head. It is used for diagnostic purposes by striking it against the knee, and first holding it about one inch from, and directly external to, the external meatus, and at the same time asking our patient to observe closely the intensity of the sound. It is again struck against the thigh just above the knee and made to vibrate with equal velocity, and the handle, which is made round, placed on the forehead, mastoid bone, or teeth. If the nerve be healthy, no matter how great a defect of hearing we may have, it will always be heard with distinctness when placed in contact with the bone. This is denominated bone conductor, or B. C. But when the fork is heard best through the air, as is the case in the normal ear, it is expressed in A. C. better, that is aerial conduction of sound is better than bone conduction. In our case it was found that bone conduction was much better than aerial conduction. This excludes disease of the auditory nerve in our case. By ex-

clusion we have located the cause of deafness in the middle ear. The external as well as the internal portion of both ears was found normal. Our case, if I may be allowed to use the black board, in aural technology, is expressed as follows:

H. D. R. E. $\frac{c}{40}$	}	B. C. R. E.	Better.
H. D. L. E. $\frac{c}{40}$	}	B. C. L. E.	Better.

We have as remaining causes of the deafness in this case a disease or stenosis of the Eustachian tube, ankylosis of the ossicles, or impaction of the stapes in the fenestra ovalis, or an affection of other appendages of the cavity of the tympanum.

Hearing is described by physiologists as being sounds collected by the external ear and transmitted to the membrana tympani. They are here modified by the tense or lax state of this membrane, produced by the action of the tensor tympani muscle. The modified vibrations from the membrana tympani are thence conducted along the chain of bones to the fluid of the labyrinth, and through it transmitted to the auditory nerve, which receives the impression and conveys it to the sensorium. Conditions that would modify this normal auditory impression are, an impervious Eustachian tube, which would exclude air from the middle ear; impaction of the stapes, or ankylosis of the ossicles, thickening of the membrana tympani, or contractile tissue, that restrict oscillations and vibrations. The most common cause of deafness, outside of these, with a congenital origin is catarrhal inflammation of the middle ear, which may have been suppurative or non-suppurative. Throat troubles, either acute or chronic, extending to the drum through the Eustachian tube, are frequent causes.

From statistical tables I have recently arranged as to the cause of deafness, it was found that of all cases of classified causes, twelve per cent was a result of scarlatina. These tables were compiled from the reports of every Deaf and Dumb Institute in the U. S., and are presumably correct. It has been determined by careful post mortem investigation that scarlatina produces an ankylosis of the ossicles, or an impaction of the stapes into the fenestra ovalis according to Allen, and ankylosis according to Toynbee.

As previously stated the membrane was slightly depressed, or the concavity was increased somewhat. This would indicate contraction of tissues or rigidity of ossicles. The case under consideration is one of impaction of the stapes into the fenestra ovalis, or impairment of the

conducting power of the ossicles in some way. The indications for treatment which have been determined by clinical experience, would be inflation either by Valsalva's method, the Politzer's bag, or by the Eustachian catheter. Owing to the apparent obtuseness of our patient, it was impossible to practice Valsalva's method, which consists in holding the nostrils and having him forcibly distend the pharynx with the air of the lungs, which act forces air through the Eustachian tube into the drum. As the catheter is generally objectionable owing to its unpleasantness to adults as well as cause for complaint on the part of rebellious youths, the Politzer method of inflation was adopted. The Politzer apparatus consists of a rubber bag, either with or without a side perforation, and a tube about 12 in. long to the end of which is attached a tip of polished wood, vulcanite or other material made to fit the anterior nares. The method of inflation consists in first having the patient take a small quantity of water into his mouth and hold it there until you have inserted the tip on the end of the tube a little ways into one of the nostrils; next grasp the nose with the left thumb and fingers, and for the time seal the anterior nares. With the bag in the right hand, you direct your patient to swallow and at the moment the pomum Adami begins to ascend you forcibly expel the air in the bag. The act of swallowing, as is well known, throws the velum palati against the posterior wall of the pharynx and makes two cavities of it, the superior cavity communicating with the nares and Eustachian tubes, and the inferior cavity with the buccal cavity, larynx and pharynx. By forcing air into the upper cavity thus formed, the Eustachian tubes are forcibly opened and air enters into the cavity of the tympanum. This act does two things: first, it opens the tubes that may have been closed by old catarrhal adhesions, and second, it forcibly dilates the membrana tympani. If the membrana tympani be bound down by old contractile tissue, or the ossicles be restricted in their action by ankylosis, or if the stapes be impacted in the *fenestra ovalis*, the act of forcing air into the cavity of the drum will force the membrane out and drag the bones along and otherwise restore these structures to their normal condition. At every act of inflation you ask your patient if he feels the air going into the cavity of the tympanum, and he will readily understand you and say "yes" at every act.

While inflation is the best, and I might say the only treatment for chronic deafness, it will only cure a portion of the cases, and only those of recent origin. A patient who has arrived at the age of forty or over, and has had chronic deafness for the greater portion of his life, will not

likely be benefitted by any treatment. Unless some improvement is made after three or four inflations it is useless to proceed further. Always try the hearing distance before and after inflation, and mark the improvement.

Those cases of chronic deafness which have associated with them a roaring, or sounds likened unto the puffing of a locomotive, require in addition to inflation a vapor of iodine and camphor, one drachm of the former to two ounces of the latter. This is driven into the drum through a Eustachian catheter.

Prof. Roosa has devised a tip for the Politzer bag, which will allow the introduction of a small sponge or piece of absorbent cotton. This sponge may be saturated with the above solution and the vapor driven into the ear by the ordinary Politzer bag. It is not so efficacious, however, as the catheter. If used through the catheter the solution is put into a quinine or similar bottle. Two glass tubes bent at a right angle are passed through the cork. To one tube is attached the bag and to the other the tube which is fastened at the other end to the Eustachian catheter; by forcing the air in the bottle above the liquid, a vapor sufficiently saturated with the camphor and iodine is driven into the cavity of the tympanum to favorably impress these structures and relieve the very annoying tinnitus aurium.

It appears to me to be the duty of every physician to look up the cases in his territory and see to it that they receive treatment before they become incurably deaf, which they in almost every case do, unless the benefit of proper treatment is given them early.

The case under consideration was found on first examination to be as follows, with daily record of improvement.

		Before Inflation.	After Inflation.
February 28.	{ H. D. R. E	C-40	2-40
	{ H. D. L. E	C-40	2-40
March 1....	{ H. D. R. E	2-40	4-40
	{ H. D. L. E	2-40	4-40
March 2....	{ H. D. R. E	4-40	10-40
	{ H. D. L. E	4-40	9-40
March 3....	{ H. D. R. E	10-40	13-40
	{ H. D. L. E	9-40	10-40
March 4....	{ H. D. R. E	13-40	14-40
	{ H. D. L. E	10-40	10-40
March 10...	{ H. D. R. E	22-40	30-40
	{ H. D. L. E	12-40	13-40
March 11...	{ H. D. R. E	28-40	30-40
	{ H. D. L. E	12-40	13-40

		Before Inflation.	After Inflation.
March 12...	{ H. D. R. E	40-40	Normal.
	{ H. D. L. E	15-40	18-40
March 25...	{ H. D. R. E	Normal.	Normal.
	{ H. D. L. E	25-40	25-40
March 28...	{ H. D. R. E	Normal.	Normal.
	{ H. D. L. E	24-40	26-40
April 1.....	{ H. D. R. E	Normal.	Normal.
	{ H. D. L. E	20-40	22-40
April 5.....	{ H. D. R. E	Normal.	Normal.
	{ H. D. L. E	22-40	26-40

From the foregoing record it will be observed that after 22 days treatment or about 15 inflations, the right ear was restored to normal. The left ear does not yield so readily to treatment, but is improving gradually. The improvement appears to be permanent.

Case 2.—Elsie O., aged 18. Deaf as a result of scarlatina eight years ago. Both B. C. Better.

		Before Inflation.	After Inflation.
February 15.	{ H. D. R. E	1-40	2-40
	{ H. D. L. E	1-40	2-40
February 16.	{ H. D. R. E	1-40	1-40
	{ H. D. L. E	3-40	6-40
February 17.	{ H. D. R. E	1-40	2-40
	{ H. D. L. E	6-40	9-40
February 18.	{ H. D. R. E	2-40	2-40
	{ H. D. L. E	7-40	9-40
February 19.	{ H. D. R. E	2-40	2-40
	{ H. D. L. E	8-40	9-40
February 21.	{ H. D. R. E	2-40	2-40
	{ H. D. L. E	9-40	10-40
February 22.	{ H. D. R. E	2-40	2-40
	{ H. D. L. E	10-40	12-40
February 23.	{ H. D. R. E	2-40	3-40
	{ H. D. L. E	12-40	14-40

The above case had no *tinnitus aurium*. Case passed out of my hands after eight applications. The improvement in the left ear was quite satisfactory, and the case is one for permanent and complete recovery. Other cases might be given but as my object is to give definite formulary for systematically expressing improvement I will not tire you with further details.

MALPRACTICE SUIT.

CHRONIC ARTHRITIS MISTAKEN BY PLAINTIFF FOR IMPROPERLY TREATED FRACTURE OF FEMORAL NECK.

Note: The following report has been furnished at our request by the defendant, Dr. A. P. Courtright, of Circleville, Ohio.

Mrs. Elizabeth Henry, aged about thirty-five, healthy, four and one half months pregnant; fell on right side, January 16th, 1884, fell upon a flat stone, on which there was a thin coating of ice. Dr. A. P. Courtright saw the patient within three hours after accident, conditions as follows: After a careful examination twice repeated, he could find neither crepitus nor shortening, neither everision nor inversion; the patient could flex and extend the leg at will, could raise the heel off the bed, there was no flattening of the trochanter, which rotated in the radius of the circle described by the trochanter major. There was no appreciable difficulty in making extreme flexion, adduction, abduction or rotation, neither did these movements cause any pain, in or about the hip joint. The only pain complained of, was along the course of the anterior crural nerve, particularly centered in the middle third of the thigh. The diagnosis was simply a contusion, and absolute rest enjoined, the Dr. admonishing the patient to promptly notify him should any new symptoms occur. (Dr. Courtright saw the patient 60 days later, when the conditions were materially the same except the advancing pregnancy.) The patient remained in bed three days, and then to relieve her pain in the thigh got up and walked about on crutches, which she continued to do daily, and occasionally at night. Her only relief from pain, she said, was when in motion, and for a short time after walking.

June 1st, 1884, the patient gave birth to twin children, one a breech presentation, the other a vertex presentation, delivered by the aid of instruments: nothing unusual about her convalescence. Dr. Courtright now asked for an examination, with a consulting physician, to determine if possible the conditions resulting from the fall, inasmuch as previous to her accouchment the case was somewhat obscure. The request was not granted, and from June 12th until Aug. 18th, 1884, the patient was going about on crutches, performing all the duties of a mother.

August 16th to 18th, Drs. Thompson and Warner saw her and made an examination for supposed fracture, and found what they supposed to be true crepitus, and about one half inch shortening.

In July 1885, the patient brought suit against Dr. Courtright in the Court

of Common Pleas, to recover the sum of \$6000. 00, for alleged malpractice, averring in substance in her petition that on the 18th day of January, 1884, she broke and fractured the bone of her right leg, near the hip joint, that she employed the defendant to set said broken bone in its proper place, and to attend on her until she should be cured; that the defendant entered on said employment but was so negligent and unskillful in setting said bones and dressing said injury that he utterly failed to reduce said fracture, etc., etc.

The defendant promptly answered, and said:

"He admits that on or about the 18th day of January 1884, the Plaintiff had a fall and claimed to have been injured thereby, and employed the defendant, who was a Surgeon, to examine her condition. He avers that he made a careful and faithful examination, and that there were at that time no indications by which any skillful physician or surgeon could discover the existence of a fracture of the bone of Plaintiff's right leg, near the hip joint, if any such fracture existed."

To this answer a reply was filed by the plaintiff.

At the following term of the Court the case was continued, upon the application of the Plaintiff and at her costs. At the following term of Court, the Defendant moved the Court for an examination of the physical condition of the Plaintiff, and Prof. J. W. Hamilton, of Columbus, and Dr. N. E. Jones, of Circleville, were appointed in connection with Dr. William Warner, one of Plaintiff's physicians, to make the examination. The examination was held on January 25th, 1884, present Drs. Hamilton, Jones and Warner. The following is the minute, made by one of the examining surgeons, Dr. Hamilton, at the time:

"Found no eversion, one half inch shortening, atrophy of entire right leg, complete flexion easily performed, same true as to rotation; leg measured at instep, ankle, calf, garter, upper garter and middle of thigh. Whilst making the examination, I felt a rough rubbing sensation, akin to crepitation; this occurred a number of times, Mrs. Henry exclaiming about as often 'there that is that same feeling, but not as painful as it used to be.' She cautioned us, before beginning the examination, not to 'rotate' her limb, or rather she expressed great dread of it, because it was that, or a kind of a twist, that caused her pain. After puzzling over this matter for a long time, I found the cause of it; pressing my fingers down deeply into the soft parts on the outer part of the femur, so as to reach the outer margin of the tendon of the great gluteal muscle, I found every time the leg was rotated, this rough, rubbing sensation was produced. I repeated this several scores of times. Mrs. Henry stated that except during the first two or three days after her injury, she had been upon crutches every day and was compelled to sit up two or three times a night, that her greatest pain was when she laid in bed, or stood up, and

that she got relief by sitting up with the limbs hanging down, or by moving about gently on her crutches. The great pain was in hip and thigh, but at times it was severe in knee and ankle; it was worse during late fall, winter and early spring, better in the mild season; it was of a numb, darting and severe aching character, and was most severe at night, especially after lying quiet in the bed for some time. The two legs were of same apparent length."

The result of the examination was, that Doctors Hamilton and Jones agreed that there was no fracture, but found arthritis; in this judgment Dr. Warner did not concur.

Immediately after the result of the examination became known, the Plaintiff again had her cause continued at her costs.

About the 26th of Feb. 1886, the Plaintiff presented herself to Prof. W. W. Dawson, at Cincinnati, for an examination of her condition. The doctor made a careful examination, and in his deposition (which was afterward taken by the Defendant,) says, that he found her suffering "with chronic arthritis" of the hip joint. The Doctor was asked to state the symptoms existing, which led him to that conclusion. He answered: "There was more or less pain on movement of the joint, and when the limb was moved it gave a sound something like two smooth bodies passing over each other, and again a sound not unlike the sound elicited by bending leather. It is what we call false crepitus."

The Doctor was asked if the books did not sometimes speak of the conditions named as "rheumatic arthritis," to which he replied: "Yes; the terms chronic rheumatic arthritis, or rheumatoid arthritis, are the terms usually employed; but I have never seen any reason why the term rheumatism should be used in this connection. The disease is but little like rheumatism, and most of the cases I have seen have resulted from injuries."

The following question was propounded to the Doctor:

"State whether or not, from the examination you made of Mrs. Henry's case, it is your opinion that a fracture of the hip joint had ever taken place."

To which the Doctor responded:

"There was no evidence of it. I told her that her condition might have arisen from a contusion, or a slight impaction. There was no evidence of a complete fracture; we don't get bony union in the adult in this condition; on the supposition that there has been a fracture, *the result would have been a very good one*. In her case the *neck of the bone was solid*."

After the deposition of Dr. Dawson was filed in Court, the Plaintiff

sought and obtained leave to file an amended petition, averring injury to the ligaments of the leg, etc., etc., with the usual averments as to negligence, &c. An answer was promptly filed to this new petition, and the cause was again continued at the costs of the Plaintiff.

The Plaintiff then presented herself to Dr. J. F. Baldwin, of Columbus. He made the following brief note of the case under date of April 9, 1886: "Had injury of right thigh two years ago last January. Right leg is somewhat atrophied and flabby— $\frac{7}{8}$ in. shortening, as determined by measuring from ant. sup. spin. process to int. mal., and also by Bryant's triangle. Crepitation at hip on rotation, also on extension and flexion. Ligaments about joint seem relaxed: can draw limb down, but it goes up as against a solid point of resistance, not as though against the capsular ligament. Regard the case as one like that of Reese's: interstitial absorption with some dry arthritis."

At the next term of Court, the case was again continued upon the application of the Plaintiff, and at her costs.

And at last, at the April term (1887) of the Court, the Plaintiff dismissed her case, absolutely, at her costs.

NOTE BY DR. J. F. BALDWIN.

At the request of Dr. Courtright, I add some points that would have been brought out had this case come to trial. I was honored by Dr. Courtright by being consulted early in the progress of the suit, and in support of the hypothesis—which I regarded as the only tenable one—of arthritis (traumatic in origin), I furnished him with the following quotations under date of Sept. 8, 1885.

Barwell ("Diseases of the Joints," Wm. Wood & Co., 1881, pp. 259, 260, 262) says: "Arthritis deformans, if mono-articular, is usually, if not always, preceded by local injury, varying from a bruise or sprain to a fracture or dislocation." * * * "The limb becomes rapidly wasted and the muscles flaccid: * * at the hip, the emaciation invades the buttock, flank and thigh." * * * "Crepitation in the joint may be detected; crepitation, evidently bony, and due to the absorption of cartilage." * * * "It is to be remembered that of all joints the hip is most usually alone affected, indeed, the term *malum coxae senile* originates from that peculiarity. When mono-articular at the hip, the affection is often traumatic. The eversion of the limb, the shortening and the crepitus, are often a cause of embarrassment in diagnosis. If a person, of whom the surgeon previously knows nothing, but who has for some time suffered from arthritis deformans, come to him after a fall or severe blow on the hip, he will probably be at first led to diagnose intra-capsular fracture; and even when previous history

arouses a suspicion of other disease, he may find it difficult to assure himself that fracture does not also exist, for the two are by no means incompatible." The same writer mentions the same point, with means of differential diagnosis, on pp. 374-5, vol. IV., "Internat. Ency. of Surg." Wm. Wood, 1884.

Ranney ("Surg. Diagnosis," 3rd Ed., '84, p. 236) gives the following as "symptoms in common" of intra-capsular fracture and "chronic rheumatic arthritis with contusion:" "Both are associated with crepitus; loss of power and loss of voluntary motion; local pain in region of hip; swelling and possible ecchymosis; a history of an accident; advanced years; eversion of the foot." [*Advanced years*, while the rule, is certainly not without many exceptions.]

Erichsen (Lea, 1878, vol. 2., p. 231) says: "It occasionally happens that an individual laboring under this affection [rheumatic arthritis], meeting with a fall or contusion of the hip, presents signs of *fracture of the neck of the thigh bone*, such as shortening, eversion, with some crepitation perhaps, and inability to move the limb."

Gross, (Lea, 72, vol. 1, p. 1025) in speaking of intra-capsular fracture, says: "The changes now described are sometimes closely imitated by those produced in the head and neck of the femur by a fall or blow on the hip, leading to interstitial absorption of the osseous tissue, and to shortening of the limb, with destruction of the articular cartilage and eburnization of the resulting stump, very much as in arthritic rheumatism. There is reason so believe that cases of this kind are not infrequently mistaken, both during life and after death, for fractures of the neck of this bone." (p. 1077.) "The pain [in rheumatism of the hip joint], which runs down the front of the thigh, is dull, heavy and aching."

Hilton ("Rest and Pain") describes a branch of the anterior crural (p. 193) which goes to the hip-joint: thus accounting for a "sympathetic" pain, in hip-joint disease, along the course of the anterior crural. (I cannot find that any other anatomist has described this branch.)

Hamilton ("Fractures and Dislocations," 1884, p. 439) gives a case in which this form of disease followed a blow on the hip.

I was consulted by the plaintiff April 9, 1886, and Dr. Courtright has given the result of my examination. April 29, 1885, I wrote as follows to her physician:

Dear Doctor.—I failed to get the authorities I wanted in Philadelphia, and only received them yesterday from Washington.

I think your patient is suffering from the effects of *monoarticular-arthritis* and *interstitial absorption* of the femoral neck.

We discussed that aspect of her case when you were here, but the question of *time* stood in the way of your accepting that hypothesis.

Paget (*British Med. Jour.*, Feb. 19, 1870, p. 183) says the shortening, from interstitial absorption, comes on "weeks or months after a contusion of the hip."

In the case of Haire vs. Reese (McClelland, *Civil Malpractice* p. 292), the plaintiff sustained an injury of his hip Feb. 2. Dr. Reese made his last visit May 10. "On or about the sixth of August following, the plaintiff called upon Dr. Agnew [D. Hayes] at his office. Dr. Agnew then observed that there had been some shortening of the leg. When asked by Dr. Agnew when that shortening had commenced, he replied that 'it was after he had got up to go about on crutches.'" The time here, until Agnew saw him, was six months and four days.

Durham (London *Lancet*, Dec. '70) reports a case of interstitial absorption following injury, in which the process had advanced so far in three weeks as to result in *spontaneous fracture*. No post mortem examination, however, was held, hence his diagnosis was not confirmed.

Gulliver (*Edin. Med. Jour.*, vol. 46, pp. 97 and 313) reports several cases of this interstitial absorption.

Case 1. A boy, aged 15, "nine weeks" after the injury presented himself for examination: "the affected limb was at least half an inch shorter than the other." "Some months * * * after the limb had become considerably shorter."

Case 2. Aged 45. "On the 31st day * * * he was out of bed, and walked across the room with the assistance of a stick; and in three weeks more he was walking about the hospital with tolerable ease. Previous to his dismissal it was observed that the injured limb was shorter than natural; * * * the shortening was found to amount to about one half an inch."

Case 3. Time of appearance, and amount, of shortening not stated.

Case 4. Time of appearance not stated. $1\frac{1}{2}$ in. of shortening found at autopsy three years after injury.

In commenting on this subject, the writer says: "The rapidity with which the neck of the thigh-bone may be diminished, receives illustration from a case of fracture of this part recently described by Mr. Howslip, in which the neck had lost half an inch of its length by absorption on the third week after the accident."

The above cases show that *seven months* would be ample time for a shortening of $\frac{7}{8}$ in., or even more.

As to the *arthritis*, I need only refer you to Hamilton (Frank), Gross and Barwell, for statements as to its liability to occur after contusions, and also as to the frequency with which such cases are mistaken for fractures.

Very truly yours,

J. F. BALDWIN.

QUININE IDIOSYNCRACY.

A. J. Learned, M. D., Millfield, O.

On March 22, 1887, was called to see J. R. W., a blacksmith, aged 22. He was suffering from a rather severe attack of mumps, and thinking to "reduce the fever," had taken what was supposed to be about six grains of sulphate of quinine, a half or three quarters of an hour before I saw him. He was suffering with symptoms precisely similar to those of a severe paroxysm of asthma, and an urticarious eruption over the whole body. He informs me that this is the third time that quinine has affected him in this way, and that a cousin never can take it without suffering in the same manner. The urtication was described as being extremely severe and beginning about half an hour after taking the quinine and continuing for five or six hours.

In volume I, page 447, of the *Ohio Medical Recorder* (March 1877), Dr. R. M. Denig, of Columbus, gives a report of a precisely similar case, together with a translation of a case from a French journal. This effect of quinine is rare, the above cases being the only ones on record, so far as I know. Bartholow in the fifth edition of his *Materia Medica and Therapeutics*, pages 175 and 176, refers to the action of quinine being sometimes attended by an eruption of the skin, but says; "There is in fact no constant and invariable eruption, and many of the reported cases are open to the suspicion that the appearances on the skin are merely accidental and not causative."

In the cases above mentioned, the symptoms were the same in all, followed speedily the ingestion of quinine, never failed to follow its use after the idiosyncrasy was developed, and were never known to occur at any other time.

A PATIENT of Dr. Forbes, of Philadelphia, out of gratitude to the doctor for services rendered, left sixty thousand dollars to such hospital as the doctor might choose. He chose the Jefferson Medical College Hospital, of course.

DR. Masson says in the *Annales d' Hygiene et de Medicine Legale*, that it appears to him impossible that two human foot-prints should closely resemble each other unless the same foot has made them. The impression made by a foot discloses such clear characteristics; the distinctive marks under differing conditions are so numerous; the foot-prints of the same foot are so alike under dissimilar circumstances, that an attentive expert, having good foot-prints to study, ought to arrive at clear and precise conclusions. The toes, the great toe especially, leave marks that should be examined attentively; these, and the outline of the digito-planar depression, the line which defines the plantar arch, are the data for a diagnosis.—*N. W. Lancet*.

THE SEPARATION OF THE LICENSING FROM THE EDUCATIONAL FUNCTION, IN MINNESOTA.—Minnesota has for four years had a law regulating medical practice, which law has accomplished a great deal in elevating the status of the physicians of that State and in protecting the public from charlatanry. The law was defective in some points, however, and has now been superseded by another, which seems to contain almost all the desirable features of good medical legislation.

Dr. Perry H. Millard writes us that the main features of this law are: 1. The appointment of a Board of Examiners by the Governor. 2. No member can serve to exceed two terms in succession. 3. Two members are to be homeopaths. 4. All persons hereafter commencing the practice of medicine in the State must pass an examination upon the different branches. 5. Before entering upon said examination they must produce evidence of having attended three courses of lectures, if date of diploma is later than 1887. 6. Power is given the Board to refuse or revoke license for unprofessional, dishonorable or immoral conduct. 7. No member of any existing medical faculty eligible to appointment upon new Board.

The last section is an especially satisfactory one, since it divorces entirely the licensing from the teaching power.

This is what we are needing in New York State, and the lukewarm support which the present bill at Albany receives is due to the fact that it is felt, after all, to be a medical-college affair.—*Med. Record*.

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SURGERY.

EXTERNAL HEMORRHOIDS. (Chas. B. Nancrede, M. D., in *Poly-clinic*.)

Preventive Treatment.—A regular daily time for the movement of the bowels *must* be acquired, although it is a habit which may require months for its formation. Simple, well-selected food, consisting largely of fish, poultry, fresh, well cooked vegetables and ripe fruits, should be used. Strong coffee, stimulants, condiments and tobacco should be eschewed. When possible, an abundance of out-door exercise without over-fatigue should be indulged in; or if this be impossible, light gymnastics in some form, avoiding all those which necessitate straining. A cane-seated chair should be used, since the warmth induced by a cushioned chair favors local congestion. Cathartics must be avoided. If laxatives are absolutely necessary, the natural aperient waters, such as Friedrichshall or Hunyadi, should be used. Self injection of a small quantity of water before the attempt at a daily stool may suffice. On rising in the morning, after each movement, and on retiring at night, free bathing with cold water will not only prove preventive, but, to a degree, curative; a little Castile soap should be used at the morning and evening ablutions.

Treatment.—A recently formed pile, or an older one which has been bruised by a costive movement, is the most common condition for which the surgeon is consulted, on account of the great pain and inconvenience experienced. The local inflammation often produces general systematic disturbance, evinced by fever, furred tongue and anorexia. Owing to the pain, a movement of the bowels has probably been resisted by the patient, so that the first indication is a mild laxative, say of castor oil, aided, perhaps, by an enema, the last of which may consist of a couple of ounces of olive oil; or this latter may form the entire bulk of the injection. A general warm bath is desirable. The constant application of a solution of cocaine hydrochlorate, by means of absorbent cotton, will often both relieve the pain and act antiphlogistically. Pounded ice in a partially filled bladder or rubber bag, moulded to the parts, acts as an excellent sedative, and occasionally aborts the inflammation when used during the early stages of the attack. If not seen until later on, a flaxseed poultice, to which lead water and laudanum have been added, will prove a better application. The recumbent position with the hips elevated, should be enforced, and the bowels should be kept in a soluble condition, after action from the oil

has ceased, by precipitated sulphur, a seidlitz powder, or the compound licorice powder.

These measures, when resorted to early, will afford relief in the majority of cases in from one to three days, the tumor gradually shriveling up to a tab of skin, which will rarely cause future trouble if costiveness be avoided and frequent local ablutions be employed. If pus forms, a free incision is indicated. Much pain is often produced by the spasmodic and irregular contractions of the irritated sphincter and levator and muscles, which suddenly arouse the patient just as he is falling asleep. These contractions of the sphincter occasionally interfere with the circulation of the pile, rendering it edematous. As the pain has usually subsided by the time this condition has supervened, nothing more is needed than applications of lint soaked in strong liq. plumb, subacetatis, or an ointment composed of equal parts of the ointments of tannic acid and belladonna. Such tumors, however, take a long time to shrink. The rule is, that the bulk of external piles disappears by absorption, but sometimes they remain little decreased in bulk, painless, liable to become inflamed and always annoying. If frequent ablutions and regular action of the bowels do not prevent trouble, the piles may be excised after the manner recommended by Van Buren. An incision radiating from the anus should be made through the integument, which must be separated from the tumor, well down to its base; the pile is then to be seized by toothed forceps, and excised by scissors curved on the flat. By this mode of operating, all risk of contraction of the anal orifice is avoided. After the removal by incision of the clot in the first variety of pile described, it is better to place a little cotton at the bottom of the wound, and confine all in place by a compress and T-bandage, since I have seen severe and repeated hemorrhage follow such an operation in the hands of another, where I was compelled to use the clamp and cautery to arrest the loss of blood.

Owing to the irritation of the sphincter caused by the excision of external piles, which results in uncontrollable pinchings of the small wounds, these operations should never be done unless really necessary, owing to the troublesome, painful and tedious inflammation which sometimes follows.

The four following points concerning external piles should be always borne in mind: "1, their identity, as to etiology and pathology, with internal piles; 2, their preventibility by intelligent hygiene; 3, the liability to mistake other growths at the anus for external piles; 4, that they may become inflamed without involving internal hemorrhoidal tumors, if these

are present ; and, finally, the dominant influence of the powerful external sphincter muscle in obstructing their circulation, in aggravating pain when they are inflamed, and in delaying their cure."

THE PRIMARY ANESTHETIC STAGE OF ETHER.—(Dr. John H. Packard, surgeon to the Philadelphia Hospital, in *Polyclinic*.)—I would like to say a few words about giving ether for its first anesthetic effect. The effect of administering ether in this way is much like nitrous oxide. Its advantages are very great. A man comes into your office with a painful abscess of the finger, and you propose to open it. If you give ether to full insensibility, you have to keep him in your office for two or three hours, which is a great inconvenience. If you do the operation at his house, he has three or four hours of headache and discomfort, whereas if you give ether to the first insensibility he recovers immediately and perfectly. You can let him sit down and hold one hand up while he holds the ether sponge himself. When the hand drops you have a period of from thirty to ninety seconds, in which the man is in a state of insensibility, during which time you can open an abscess, or reduce a dislocation, or perhaps even replace a hernia. In a few minutes the man is fully recovered, and is able to walk away. I think that this method of administering ether is absolutely free from danger. It has been objected by good authorities on the subject of anesthetics, that partial anesthesia is always a condition of peril. Very good ; but you do not keep the patient in a state of partial anesthesia. You simply take advantage of a stage through which he must pass, and therefore you do not add in the least to the danger.

TRANSPLANTATION OF SKIN FLAPS.—Thiersch's method of healing large open wounds by the transplantation of large flaps of skin in place of the small skin grafts formerly used, is thus described by a writer in the *Buffalo Medical and Surgical Journal*: The copious bleeding is stopped by pressure with compresses for about ten minutes, the compresses being soaked in a solution of chloride of sodium. (6 to 10 per cent.) Corrosive sublimate or other strong disinfectants must not be used, as they destroy the vitality of the cells. When the bleeding is stopped, the flaps are cut out from the well-cleaned leg or arm with a razor. The flaps should be from five to ten centimeters long, one to two centimeters broad, and are transferred from the razor directly on the shining surface, and by aid of two probes completely unfolded. They should be as thin as microscopical preparations. With a soft sponge, dipped in the same solution, they

are pressed against the wound, and care must be taken that no air bubbles or blood are retained under them, and that the margins lie smoothly; otherwise, pus and secretion may work in under the flaps and loosen them. After the wound is closed with the flaps, it is covered with protective, dipped in the same solution, an antiseptic occlusive bandage is applied and left undisturbed for eight days, and when then removed, you will find the flaps adherent and the wound almost healed. I told you that these flaps adhere to almost all tissues, even to bone deprived of its periosteum, and that we here have a method by aid of which even very large wounds may be healed with astonishing rapidity. In course of time, the flaps grow in thickness and become movable on the underlying tissues.—*N. W. Lancet.*

THE TREATMENT OF HEMORRHAGE, AND OF VOMITING AND PERITONITIS, IN OVARIOTOMY.—W. Gill Wylie, M. D., after an experience of one hundred and twenty-five laparotomies, concludes:—

“*First.*—That hot water cannot only be safely used to wash out the peritoneal cavity, and that it is a simple and efficient hemostatic for oozing points too numerous and small to tie; but that in prolonged operations, and immediately after the operation, free irrigation of the peritoneal cavity with water at 105° to 110° is a powerful and efficient agent, it lessening, if not preventing, the effects of shock. Towels wrung out in hot water have been used to protect the intestines when turned out of the cavity; but I do not know that hot water irrigation of the peritoneum for shock has ever before been suggested. The temperature of the hot water must not exceed 110° , or it may cause shock.

“*Second.*—That the tympanites and vomiting and other symptoms supposed to be due to septic peritonitis after laparotomy, are best overcome by enemas, and if these fail a quick purgative. That in these cases, at least, the bowels should be moved, and not kept constipated, as has been generally practiced. That it is probable that in many cases the persistent and exhausting vomiting may be the direct result of intestinal obstruction, the result of bands of adhesions constricting the intestines. For a long time I have seriously doubted the existence of septic peritonitis in some cases where the vomiting preceded the rise of temperature and other symptoms of sepsis. By experience I have found it best to move the bowels whenever indicated by tympanites or vomiting, even during the first twenty-four hours after the operation—of course, making a distinction between these symptoms and those due to the effects of

ether. The vomiting from ether is likely to be preceded by marked nausea, and is usually violent and gagging in character, while that from obstruction is passive and more like eructation. The quantity vomited is large, and at first brownish colored, and attended with extreme exhaustion and marked tympanites. Without doubt the opium treatment taught by Dr. Alonzo Clark has proved to be the best plan for limiting local peritonitis, and when carefully carried out may prevent death in some cases of general peritonitis; but I am certain that it is not best suited to septic peritonitis following laparotomy. I usually give enough opium or morphine to relieve pain and restlessness, and keep the respiration down to 16, or even 12 in some cases. But when tympanites or eructive vomiting begins, I at once move the bowels by turpentine or ox-gall enemata, or by a seidlitz powder or Rochelle salts.

"I took the hint from a remark of Mr. Lawson Tait, that a brisk purgative would cure septic peritonitis, but the method of effecting it and the explanation as to preventing intestinal obstruction are my own."

VALUE OF INCISION IN TONSILLITIS.—Mr. Charles Maclean writes in the *British Medical Journal*:

I am induced to remark on the above subject from the fact that I have found free incisions of more avail in quinsy than in any other kind of inflammation. It is a disease little amenable to ordinary methods of treatment. It is attended by an extraordinary, and in some constitutions a very serious amount of suffering; and yet it is a local affection, and within easy reach. One book in my possession recommends opening the abscess when suffocation is imminent; another says that puncturing the swelling may be tried. The necessity of the former of these recommendations is at once obvious; but I would be inclined to anticipate this critical state, which occurs after prolonged fever and suffering. As to puncturing, I do not know that I have found it of any service at all. A large incision, however, seldom fails, in my experience, to modify the course of the disease almost at once. A case I had a little time ago serves to illustrate this. I was called in the evening to see a patient who was said to be speechless and to have "lockjaw." His snowy-white tongue, his pulse and temperature indicated high inflammatory fever. I opened his mouth, carefully inserted a bistoury, and made a good long incision in the most prominent part of the swelling. Free venous bleeding ensued for some minutes, and soon after it ceased the patient was asleep. In the morning, in reply to my question, he expressed himself as being

"quite well." All the symptoms—constitutional and local—had vanished.

I have the greatest possible respect for the internal carotid artery, and no person can have a greater dislike for needless operations than I have. Here, however, there is a distinct object to be gained by operating, and, as regards the vessel in question, a vertical incision in the region of the tonsil cannot injure it, especially as in this complaint the swollen gland tends to push the artery outwards.

NOVEL SURGICAL PROCEDURE.—One of the latest ideas in esthetic surgery is in reference to evisceration of the eye. Heretofore when that operation has been done, the wound has been closed and the remaining tissues have atrophied into a species of stump. It is now proposed that after the contents of the globe have been removed by a Volkmann's spoon, the cavity shall be filled with a silver ball of suitable size. The wound is closed by drawing together the edges of the sclerotic and of the conjunctiva, healing takes place, the ball remains without producing any irritation, and the proper size of the globe is retained. This operation has been performed successfully several times.

CHRONIC ENLARGEMENT OF TONSILS.—Dr. Beresford: By the use of a strong solution of tannic acid injected two or three times a week, with the daily use of a gargle of the same, the knife never need be resorted to. I have used the above treatment in the case of a young man, aged twenty years, with good success. I made an application of muriate of cocaine before inserting the needle, and used the injection every three days.

THE TOOTH-BRUSH TO CHECK HEMORRHAGE.—Dr. Hal C. Wyman, of Detroit, (*N. E. Med. Mo.*) has found that in plastic operations, where it is important to check all hemorrhage, nothing checks the oozing so well as brushing the surfaces thoroughly with a tooth-brush.

The principle, concerned in the use of this instrument as an agent for controlling hemorrhage, is the same as that which operates in the use of the curette in various intra-uterine surgical operations, viz., a laceration or teasing of the blood vessels so that the blood corpuscles become entangled in a mesh of fibrous tissues and thereby plug the vessels, preventing the escape of blood. Or the internal coat of the small vessels retracts and plugs the opening from which blood would otherwise escape.

When the incision is made and the blood begins to ooze freely from its sides and bottom, the brush is stroked briskly over the wound, con-

stantly brushing away the blood as it oozes out until under the frequently repeated brushings, the cut vessels are frayed or teased out, and the mesh of lacerated tissues traps the blood corpuscles and coagula preventing further hemorrhage.

In the removal of small papilomatous tumors known as urethral polypi, when very troublesome hemorrhage not infrequently follows, in cleft palate and hare lip, and in the removal of cicatrices and of nevi from the face, he has found the brush a most useful instrument in hastening the termination of the operations.

WHAT TO SAY TO CANCER PATIENTS.—(Robert T. Morris, M. D., in *Progress*.) Many cases of cancer are not well managed, and yet I doubt if any other chronic disease will swing so easily on the pivot of good treatment. Because the notion that cancer is necessarily fatal is widespread, patients do not make a move as a rule until the disease has crept far along the tissues and into the lymphatic nooks; and because the results of treatment in hopeless cases are not good, the people believe that such results are to be expected from any treatment or any case of cancer.

The surgeon who makes a diagnosis of cancer, and who expresses his opinion in the presence of the patient, is very apt to suppose that his views are accepted, but if he could follow that patient for a month, and could see him entering the office of numerous doctors in the vicinity, and could hear the different expressions of opinion regarding the case, he would not be surprised at the attitude of dejection which the patient soon assumes.

There is nothing fanciful in this statement, for it is a plain, unvarnished fact that cancer patients regularly go from one man to another, until they arrive at the office of some advertising charlatan who promises a cure, and who presents testimonials, showing that he removed a white cancer of twenty pounds weight from the shoulder of Mr. Jones, and a blue cancer of forty years standing from the leg of Miss Smith. This man gets the case, and when the patient dies his friends say that only one man promised a cure, and that man failed—ergo, when doctors promise to cure cancer they fail to do it.

I had not realized the fact that very few cancer patients are properly treated until a few years ago, when a physician who labors in a little village in this State told me that to his knowledge fifteen of his patients

had, in the preceding year, gone for treatment to a "cancer doctor" a couple of hundred miles away, who "drew out" the disease.

It is unfortunate that patients so often fail to understand the surgeon who speaks guardedly about a case of cancer, but that they are more than likely to hear incorrectly, there is no doubt whatever; and it really requires a trained listener among the laity to fully appreciate what any professional man—physician or lawyer—has to say when speaking from a standpoint of professional experience. It is the rule with some public men to insist on reading the reporter's notes after an interview; and acting on this plan I have sometimes asked patients to take notes, and tell me afterward what I said to them. Conclusions formed by the patients have often been fantastic. To bring up a matter of this sort here may seem commonplace; but since I have adopted the plan of *writing out for the patient* the statements which are to be remembered, a great deal of satisfaction has been obtained for all parties interested, and when a hopeless case dies it does not have the effect of keeping hopeful cases from coming for treatment.

No surgeon can appreciate the effect of a written statement of the case in the hands of the patient until he has made a practice of furnishing such documents. The patient reads the paper, his friends read the paper and every cancer patient in the vicinity who hears about the paper will want to read it.

To a patient, aged forty-five years, with a small epithelioma of the lip I might say as follows (and should then put the statement in black and white:) The chances for a cure or a fatal ending of the case, are about equal if you follow the advice of some one competent surgeon. The "drawing out" method of treatment (arsenious acid, terchloride of zinc, or pyrogalllic acid) would perhaps give as good a result as an operation in this particular case, but the operation will be more speedy and less painful. One treatment will, on general principles, be expected to give relief for one or more years, and the surgeon must be visited at the first appearance of each return of the disease if a cure is to be hoped for. There is no medicine which is known to be of any use for curing such a case.

To a patient, aged forty-five years, with a scirrhus cancer of the breast, of moderate size, and of either slow or rapid growth, I might say: It is possible to cure you completely by a radical operation performed according to the methods of to-day. You will probably not be cured. An operation will be expected to give you relief for one or more years, and

if each recurrent growth is removed soon after its appearance the disease will not be fatal until it appears in some of the internal organs. An operation will expose you to little if any danger. There will be no appreciable amount of inflammation after the operation, and when the first dressing is removed at the end of three weeks the wound will be healed. Internal medication will not cure the disease. "Drawing out" methods of treatment will be inefficient and will expose you to danger. There are no secret methods of cure—known to a few men only—who make claims in opposition to this statement.

To a patient, aged forty-five years, with a scirrhus cancer of the breast, of large extent, involving the periosteum of the ribs, I might say: There is no possibility of a cure. You will be much more comfortable if the cancer is removed. There will be little danger in an operation unless the ribs have to be resected. You can, perhaps, enjoy a year of fairly good health, but general infection will take place soon. No surgeon of repute will wish to operate in your case, but such a surgeon may consent to operate for the purpose of giving you short periods of temporary relief.

To a patient aged forty-five years, with a cancer of the neck of the uterus, I might say: Removal of the uterus may give you relief for a year or for several years. Chances are in favor of the short period rather than of the long one. The operation is somewhat dangerous, but the attempt is well worth the risk.

To a patient, aged forty-five years, with an epithelioma of the leg below the knee, involving the bone but not affecting the lymphatics of the groin, I might say: It is possible to cure you completely by amputating the leg above the knee. The chances are about even that the disease will return. A less extensive operation will do little to stay the progress of the disease. No other method of treatment will be of avail in an attempt at eradicating the cancer.

It is not hard to know what to say in cases similar to the ones above referred to. But, perhaps, a large majority of cancer patients will present features, the testimony of which will not give us many clues to the prognosis. There will be cases in which the disease has progressed rapidly to an extent which would auger badly for the patient's chances for escape, and yet the disease seems to be quite local, and tissues at a little distance, and lymphatic glands a few inches away are apparently not involved. In such cases it is, perhaps, best to say to the patient that the disease must be expected to return at no late date, but that repeated operations during

the next year or two will give intervals of relief, which are so complete that health and strength will be regained to a marked extent, and it is not impossible that a respite of several years may eventually be gained.

About nine years ago I operated upon a woman forty-one years of age, who was weak and anemic, and in a condition bordering on nervous prostration. She had a large ulcerating scirrhus cancer of the left breast, which involved the pectoral muscles and the near lymphatics. I removed all bad and suspicious tissues very thoroughly, and since the first operation have removed about once in seven or eight weeks a small recurrent growth situated near the large scar. In the interval the patient has grown strong and courageous, has lost her terrible nervousness, and has increased remarkably in weight. The patient is on the alert for every sign of recurrence, and she is now eager to have each new growth removed promptly.

RUPTURE OF BICEPS.—A case illustrating an unusual accident and a novel method of treatment was presented, shown at a recent meeting of the Academy of Surgery by Dr. Thomas G. Morton. A laboring man, while working in an excavation throwing dirt to the street above his head, suddenly felt something give way in his right arm which at once became useless. Examination showed that there had been a rupture of the long head of the biceps. An incision was made over the body of the deltoid, and a second incision over the tumor formed by the contracted biceps. The tendon was then grasped with forceps and pushed between the intervening bridge of skin until it appeared in the upper incision. The fibres of the deltoid were next separated at as high a point as possible, and the tendon inserted and secured with cat-gut sutures. The wounds were then closed and treated in the ordinary antiseptic manner and healed without complication. When presented to the Academy a few weeks after the accident, the patient had good use of the arm and could flex it with considerable force. — *Progress.*

EXAMINATION OF THE HIP-JOINT THROUGH THE RECTUM.—Valuable information as to the condition of the acetabulum may be obtained by examination with the finger in the rectum. Three cases are reported by Schmitz in which the patients were children, from three to five years of age, in whom symptoms of coxalgia had existed for three, six, and twenty-one months respectively. In all three the thigh was slightly flexed, abducted and rotated inwards. In one case rectal palpation revealed a well-defined tumor in the acetabular region, in the others abscesses vary-

ing in size from a hen's egg to a nut were detected. Movement of the femur during anesthesia produced no friction. Resection was performed in all the cases, and the head of the femur, with its cartilage, was found to be quite healthy, but the acetabulum was extensively diseased. Schmitz recommends the use of this method of examination in all cases of suspected hip-disease.

OBSTETRICS.

MAMMARY ABSCESS.—The pathological conditions, known as “the weed” and mammary abscesses, are but too well known to need description in this paper. Suffice it to state that the “weed” is the preliminary, which unchecked results in abscess. Now I lay it down as a rule that with proper precautions and treatment a mammary abscess should never occur. Let us take a common-sense view of the matter: When the child is born the breast is generally barren of milk, and nothing can be expressed from it but a pale, grayish fluid filled with flocculi; on or about the third day, however, the breasts enlarge, their vessels become turgid, and the gland is in a condition of great excitement, and the whole nervous system shows a high degree of tension, evidenced by a greater or less degree of fever, known as the milk-fever. Although the breasts are tense and hard, there is but little milk in the ducts of the glands, as might be supposed, but the turgidity is due to the enlargement of the sanguineous system of the organ. When secretion is thoroughly and completely established, and the milk is sufficiently withdrawn from the mammary ducts, a positive degree of comfort and ease is experienced by the mother; the tension is relieved and the breast becomes soft and painless. In order that these physiological processes may take place promptly, it is necessary that the infant should be able to play its part in a vigorous and persistent manner; and that it may be able to do this it is necessary that it should be hungry and have a normal stomach. We, however, generally find when a mammary abscess is threatened that some nurse with mistaken kindness has come to the sage conclusion that God Almighty forgot to make provision for the youngster during the first two or three days of its existence, and supplements his work by filling the hiatus—stuffing the stomach—with either diluted sweet milk, or catnip tea, or puts the new-comer to sucking the grease from a piece of raw pork. The consequence of which wise forethought on her part, is an irritated, dys-

peptic stomach, the feeling of hunger is absent, and when the child is called upon to perform its part of the contract, it rebels in disgust, and the beautiful harmony of the laws of God is disarranged, and the result is the cake or weed, the forerunner of the abscess. We, therefore, formulate the rule: In such cases never give food or sustenance to the child except what may be afforded by the breasts of the mother. Should, however, the child be unable to exhaust the breasts of the mother, its efforts may be supplemented by the use of the breast pump.

In spite, however, of all our care, either from the mother "catching cold" or some other reason, a cake or weed, sometimes accompanied by a rigor, will make its appearance. This is a critical time with the mother, since it is of such common occurrence that every old woman has a certain cure for it, and immediately the beeswax and tallow is set to boil with the "cere cloth" imbedded therein, and the camphor is rubbed on the breast, or Radway's Ready Relief, or some other stimulating liniment, and while nature, in spite of these remedies, sometimes brings about resolution, they too often hasten the catastrophe, and the first the physician hears of the case is when he is sent for, with a hint to bring along the lancet to open the abscess.

There is one remedy, however, which in my hands has proven itself to be a veritable Samson in dealing with recently-formed cakes in the breast, and that is the iodine ointment of the U. S. P. Its efficacy in the resolution and softening of inflamed and congested glandular tissue, is, if anything, more prompt and efficient when applied to the mammary than any other gland. I therefore formulate another rule: See that every nursing mother is supplied with a box of iodine ointment, with instructions that whenever she feels any soreness or discomfort or cakes or hard places in the breast, to smear the affected part with the ointment every time the child is removed from the breast, and to supplement the efforts of the child with the breast pump if necessary. In endorsement of this line of procedure, I can truthfully state in the period of twenty-five years during which I have been guided by it, when the directions have been observed, I have never opened a mammary abscess in one of my own patients.

Sometimes, however, before your attention has been called to the case, structural changes have taken place in the gland tissue to such an extent that suppuration is inevitable. In such a case you will find that the assiduous application of the iodine ointment will soften up the portions of hardened gland, contiguous to the focus of suppuration, and the pain will be mitigated and the tension relieved.

It will frequently occur that after an abscess has been opened it will be deemed advisable to dry up the diseased gland. This may readily be accomplished in a few days by the constant application of the ointment of the extract of belladonna and lard, keeping an eye to the physiological effects of the belladonna on the general system, through the process of absorption, although I have never seen any such effects when applied for the purpose hereinbefore indicated; but we must remember that some persons are peculiarly susceptible to remedies applied to the skin.—*News*.

NURSING SORE MOUTH.—The next pathological condition to be considered is that known in common parlance as “nurse’s sore mouth.” In my opinion the disease is neurasthenic in its character, evidently caused by the debility consequent on abundant lactation. I have met with many cases of different degrees of intensity, and by deduction have arrived at the conclusion that in many the whole alimentary tract is involved in the ulcerative process. In one case I was satisfied that such was the case, the mouth being a mass of ulcers, the abdomen tender on pressure; dysenteric discharges being frequent, and the patient exhausted with an irritative fever. The usual treatment for “nurse’s sore mouth,” or the stomatitis of lactation, consists in the local use and internal administration of chlorate of potassium, or golden seal, and the usual treatment is of no avail whatever. There is a remedy for this disease, however, as potent and reliable as is quinine in an intermittent fever, and that is the nitrate of silver in combination with opium.

R. Argenti nitratis.....gr. 20 to 40.

Pulv. opii.....gr. 10.

Ft. pil. no. xl.....

SIG.—One pill one-half hour before each meal.

This will be sufficient in ordinary cases, but when the system is utterly exhausted and the whole alimentary canal seriously involved, it may become necessary in addition to remove the cause by drying up the milk, which may readily be accomplished by the removal of the child from the mother.—*Ibid*.

RESUSCITATION OF ASPHYXIATED INFANTS.—(T. C. Smith, M. D., of Aurora, Indiana, in *Med. and Surg. Reporter*.)—Take the infant by the lower extremities with the left hand, suspend it head downward, then with the right hand embrace the neck posteriorly, using for this purpose the thumb, ring and little fingers, while the index and middle fingers support the head. Now hold the head and shoulders downward and com-

paratively still, while with the left hand the body and feet are made to sweep forward and backward from ten to fifteen times or more in a minute, until respiration is established. Each time that the body is bent forward on the face the air is pressed out of the lungs, and when bent well back again the air enters the lungs freely. Keeping the head downward causes a full supply of blood to be given to the brain. This process does not prevent fanning, or sprinkling suddenly a little cold water on its sides by an assistant if needed for the shock it produces. Clothes wrung out of hot water can also be applied if needed. It is not good practice to lay an asphyxiated infant on its back, for if there is mucus in the mouth or throat this will tend to strangle it. If placed on its side or with face downward this cannot occur, or, as least, is less liable to do so. If there is enough mucus in the child's throat to cause considerable noise by its rapid succussions in process of respiration, all this will cease in a little time by placing the child face downward, or on its side with its face inclined downward. In this way the mucus will gravitate away from, rather than into, the throat. Of course it can be otherwise removed, but this is an easier and a very ready way to obtain relief from this harassing symptom.

Some have claimed that the Marshall Hall method of artificial respiration will not cause air to enter the lung of an infant where the respiration has not already been partially established. In the method above recommended, one can readily satisfy himself of the entrance and exit of air into and from the lungs every time the infant's body is well bent forwards or backwards, for the evidences will be unmistakable and easily observed.

MORTALITY OF FOUNDLINGS.—From some inquiries recently made at the Philadelphia Hospital we learned that of sixty-six foundlings received during four years into that institution, thirty-five died within the first year. It is true, some of these deaths were caused by measles, but the great majority of these infants perished from what, though commonly known as marasmus, really means starvation. Now the secret of this starvation was not an inadequate supply, or absolutely unsuitable character of food, or failure to give it at proper intervals, but too much was given.

The most frequent mistake in the artificial nourishment of newborn infants is giving them the quantity of food which the infant at six months, for example, requires; disorder of the digestive organs quickly follows this constant overloading the stomach, and the child soon loses its plump-

ness, then becomes rapidly emaciated, gastric catarrh and diarrhea set in, and the poor creature dies starved to death by over-feeding. The proper remedy, the true way to prevent this evil in public institutions, and often in private practice, is to have nursing-bottles which will hold only the quantity of food needed: for example, instead of using a bottle which holds four or six ounces, as that generally used does, employ one which will hold only two ounces, for an infant during at least the first two months of its life. We believe, if this rule be observed, the mortality of hand-fed infants would be materially lessened.—*Med. News.*

CHLORAL IN LABOR.—For a great many years I have been using chloral in cases of labor, with remarkable results. When I am called to attend a woman in labor, and find the os undilated or rigid, I invariably inject into the rectum 30 grains of chloral dissolved in about four ounces of warm water, with a little starch added. I have used this means for eight years, and have failed to get any but the most flattering results; in fact, I cannot prize the method too highly. On the 28th of this month I was called to a case of placenta previa; the woman had been flowing all night, and when I got there at 6 o'clock a. m., she had lost much blood. I found the os rigid and undilated. I immediately injected my favorite remedy, and in less than three minutes the os was dilated so that I could readily pass my hand into the uterus, and the rectum, vagina and perineum were well relaxed. The drug has never failed me yet in this connection, and I would like to commend it to others who may not have used it.—*Med. Age.*

POST-PARTUM HEMORRHAGE.—Dr. De Cailhol recommends (*So. Clinic*) that the accoucheur carry into the uterus with his hand a peeled lemon, and squeeze it there, at the same time pressing and manipulating the uterus with the other hand externally.

This would seem to be a substitute for Goodell's method of carrying into the womb a cloth or sponge saturated with vinegar.

DRUGS WHICH INCREASE AND DRUGS WHICH DECREASE THE SECRETION OF MILK.—Giurleo calls attention to the peculiar properties of *Ditana digitifolia*, which, he claims, possesses the power to stimulate the secretion of the mammary glands. The author found an opportunity to try the remedy on a number of wet-nurses, and pronounces himself as extraordinarily satisfied with the results obtained. In some instances, in which the secretion was almost wholly absent, the ingestion of an infusion of the plant produced a copious supply of milk. In Italy an ethe-

real tincture of *Ditana digitifolia*, combined with syrup, has been known for a long while under then name of "galatiofore." The blossoms and buds of the plant, besides, possess diaphoretic properties. The same author asserts that *Rhamus alaternus* and *Ligustrum vulgare* have properties precisely opposite to those of *Ditana digitifolia*—i. e., they decrease the secretion of milk. The author uses an infusion of the plants (forty-five grains of the leaves to six ounces of water,) and orders for several days this quantity of the infusion to be used up twice a day.—*Therapeutic Gazette*.

A NEW THEORY AS TO THE CAUSE AND TREATMENT OF VOMITING IN PREGNANCY.—(W. S. Higgins, M. D. in *Peoria Med. Mo.*)—Such diversity of treatment for vomiting in pregnancy indicates a vague idea as to its etiology. I have not time to elaborate, only to hint at the true cause and the appropriate treatment.

The patient is invariably a *married lady* who is unable to endure *all* the amorous husband is *anxious* to give.

After thirty-seven years active practice I have the first person to prescribe for who was abundantly able to satisfy the desires of a weaker husband. Making a note of that fact some ten years ago, I adopted a course of treatment accordingly.

Treatment—First stimulating the passions with appropriate remedies and requiring *rest* from the desires of the husband. Since adopting that as the true cause and prescribing accordingly, I have had the great pleasure of relieving each patient in a very short time. I have found *tr. cantharides* and *tr. ferri mur.*, equal parts, to suit a majority of cases admirably. Dose, 25 drops in water three times daily.

After ten years proving this as the true course to pursue with the distressing malady, I feel now justified in giving it to the profession.

SORE NIPPLES.—One of the most painful and troublesome lesions to which the recent mother is liable, is the excoriated and fissured nipple. This is caused by the rapidly alternating moistening and drying of the tender skin of the nipple, aggravated by the tension on the delicate and sensitive tissues by the act of sucking. We notice different grades of intensity in this painful and harassing condition, from the simple excoriation to the deep fissure, at times almost threatening the amputation of the nipple.

In this lesion means of prevention are more satisfactory than those of cure, and I can state confidently that with proper care a case of sore

nipple will become almost a thing of the past; and I always make it a point before discharging an obstetrical case to give full and concise directions for the accomplishment of this end. The main point in the prophylaxis is to prevent the nipple from drying in the atmosphere.

R. Boracic acid, ... 20 grains.

Mucilage of gum Arabic, ... 1 ounce.

M. Dry the nipple with a soft cloth or a bit of absorbent cotton, and apply with a camel's hair brush after each time the child is removed from the breast.

This application made to the nipple, while still soft from the child's mouth, will rapidly dry and form a coating that will shield it from the irritating influence of the atmosphere, and prevent the fertilization of any poisonous germs that may be present. I am indifferent in regard to the removal of the preparation before applying the child, as it is entirely harmless. The applications must, however, be continued until the nipple has been hardened and toughened, and no harm will result if the nipple is kept shielded by it until the end of the period of lactation.

Sometimes it happens that our first acquaintance with the case occurs after the damage has been accomplished, and our mission is then to cure, not to prevent. In such a case I know of no better general application than that of finely powdered boracic acid, dusted on the excoriations or fissures from a bag of coarse flannel, to be afterward coated with the mucilage heretofore mentioned. It may be necessary to relieve the nipple temporarily from the tugging of the infant; in such a case breast pumps will come into play. Now there are breast pumps and breast pumps, the most of which are not only utterly worthless but do more harm than good. There are, however, two "brands" of breast pumps, which are easily applied and efficient in action. These are known to the trade as the "English" breast pump and the "American" breast pump, both exactly alike in shape, material and structure, only different in their names; in fact you cannot tell them apart. They have a large bell mouth which will draw without compressing the nipple, and the suction is accomplished by releasing an India rubber chamber from pressure after the instrument has been applied over the nipple, and the power of suction can be regulated by the amount of pressure on the chamber. In extreme cases it may become necessary to dry up the breast affected, which can be accomplished by daily smearing the diseased breast with an ointment composed of equal parts of extract of belladonna and lard.—*Med. News.*

MANICURE.—There are not nearly as many secrets in manicure as people imagine. A little ammonia or borax in the water you wash your hands with, and that water just lukewarm, will keep the skin clean and soft. A little oatmeal mixed with the water will whiten the hands. Many people use glycerine on their hands when they go to bed, wearing gloves to keep the bedding clean; but glycerine don't agree with every one. It makes some skins harsh and red. These people should rub their hands with dry oatmeal, and wear gloves in bed. The best preparation for the hands at night is white of egg, with a grain of alum dissolved in it. Manicures have a fancy name for it; but all can make it and spread it over their hands, and the job is done. They also make the Roman toilet paste. It is merely white of egg, barley flour, and honey. They say it was used by the Romans in olden times. Anyway, it is a first-rate thing; but it is mean, sticky sort of stuff to use, and don't do the work any better than oatmeal. The roughest and hardest hands can be made soft and white in a month's time by doctoring them a little at bed-time, and all the tools you need are a nail brush, a bottle of ammonia, a box of powdered borax, and a little fine, white sand to rub the stains off, or a cut of lemon which will do even better, for the acid of the lemon will clean anything. Manicures use acids in the shop, but the lemon is quite as good, and isn't poisonous, while the acids are.—*N. Y. Analyst.*

CARNRICK'S FOOD, IN THE FEEDING OF INFANTS DEPRIVED OF BREAST MILK.—(J. Lewis Smith, Professor of Diseases of Children.)—No physician should recommend a food as he would not a medicine, without knowing its composition, and the composition of most of the recent dietetic preparations, ending with Carnrick's, has been announced. Carnrick's food contains a large percentage of the solid constituents of milk, the casein of which has been partially digested so as to resemble the casein of human milk in its behavior under the digestive ferment. The other ingredient is stated to be wheat flour subjected to prolonged baking, so that its starch is to a considerable extent converted into dextrine. This food has the advantage of easy preparation in the nursery, and easy digestion. Used alone it is sufficiently nutritious for the infant. It will probably supersede some of the older foods of the shops. Poor families who cannot afford to use it as the sole food, will, according to my observation, find it useful made into a thin gruel and employed in diluting the cow's milk with which these infants are fed.

The only Coca Preparation endorsed by the Académie de Médecine of France.

Used in the Hospitals, Cliniques and Public Institutions throughout Europe, and by the entire Medical Profession, since 1863.

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VIN MARIANI

(ERYTHROXYLON COCA.)

THE MOST EFFICACIOUS AND AGREEABLE OF TONICS AND STIMULANTS, AND WITHOUT ANY UNPLEASANT REACTION.

FORMULA.—VIN MARIANI is the concentrated extractive of the fresh leaves of ERYTHROXYLON COCA and an excellent special quality of Bordeaux Wine, each wine-glassful containing the medicinal properties of thirty grains of the fresh *selecte* leaves.

DOSE.—Usual dose is one wine-glassful about half an hour before or *immediately after* each meal; for children, half the quantity.

FOR twenty-five years “**VIN MARIANI COCA**” has been introduced exclusively to the **Medical Profession** and has invariably given them uniformly good results in their practice. As a strengthener of the nervous system, with especial good effect on the respiratory and digestive organs, it is pronounced superior to any other adjuvant. Owing to the large demand for Vin Mariani, imitations and substitutions are being forced on patients where physicians do not especially specify

→ “VIN MARIANI,” ←

and we would respectfully call attention to this fact, as being the cause of failure to secure good effects in many cases where Coca is prescribed.

TREATISE, 53 pages (translated from the French), will be sent **gratuitously and post-paid** to any Physician mentioning this Journal.

Price for Vin Mariani is reduced; and where druggists do not keep it, we will supply it to patients by the case of twelve bottles for twelve dollars. Remittance in all cases must be sent with the order.

To physicians, for their own use, a discount will be made.

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Combinations for

HORSFORD'S ACID PHOSPHATE.

As the "Acid Phosphate" of Prof. Horsford is more extensively used, one of its characteristic qualities, that of an adjuvant, becomes better known and appreciated. The experience of physicians of the various schools shows that it combines readily and very effectively with a great variety of other remedial agents. It is a superior substitute for the officinal Phos. Acid. Dil., as it acts more effectively, and does not produce the irritation sometimes noticed upon the exhibition of that remedy.

Below we give a series of prescriptions in combination with Horsford's Acid Phosphate, and believe them worthy the careful consideration of medical practitioners. These prescriptions are the result of careful study, and they serve to show the wide usefulness of Prof. Horsford's excellent preparation.

* These combinations are largely used by the profession.

*Acid Phosphate with Strychnia.

R
Horsford's Acid Phosphate $f\overline{3}$ viij
Strychninæ Sulph gr. j
M

Sig: Half to one teaspoonful in a glass of water.

Acid Phosphate with Quinine.

R
Horsford's Acid Phosphate $f\overline{3}$ ss
Quininæ Sulph. gr. xvj
Syrupi Simplicis $f\overline{3}$ ij
Aque $f\overline{3}$ ss
M.

Sig: A tablespoonful in a wine glass of water.

Acid Phosphate with Emulsion of Cod Liver Oil.

R
Emulsion Olei Morrhue 50% $f\overline{3}$ vij
Horsford's Acid Phosphate $f\overline{3}$ j
M.

Sig: A tablespoonful.

*Acid Phosphate with Wine of Pepsin

R
Vini Pepsinæ $f\overline{3}$ vj
Horsford's Acid Phosphate $f\overline{3}$ i j
M.

Sig: A dessertspoonful in water.

Acid Phosphate with Elixir of Iron and Quinine.

R
Elix. Ferri et Quininæ
Horsford's Acid Phosphate aa $f\overline{3}$ iij
M.

Sig: A teaspoonful in water.

*Acid Phosphate with Tincture Nux Vomica and Compound Tincture of Gentian.

R
Horsford's Acid Phosphate $f\overline{3}$ vj
Tinct. Nucis Vom. $f\overline{3}$ j
Tinct. Gentianæ Comp. $f\overline{3}$ ij
Syrupi Simplicis $f\overline{3}$ iij
M.

Sig: A tablespoonful in water.

We do not prepare the Acid Phosphate in any of the above combinations.

Physicians who have not used Horsford's Acid Phosphate, and who wish to test it, will be furnished a sample on application, without expense, except express charges on application to

RUMFORD CHEMICAL WORKS,

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MEDICINE.

THE TREATMENT OF COLDS.—(J. H. Whelan, M. D., R. N., in *The Practitioner*.)—Of all disagreeable constitutional tendencies, the tendency to “catch colds” is the most disagreeable to the individual, and besides its unpleasantness there is always the danger that a catarrh may outstep its usual limits and develop into some grave inflammation.

Is the nature of common catarrhs generally understood? To a certain extent I think it is, but not fully. Let me enunciate the broad characteristics of colds. Catarrhs are excited *de novo* by exposure to wet, colds and draughts. This is a truism. Most frequently they develop in delicate and highly neurotic individuals, in fact in the classes which furnish martyrs to common neuralgia. I believe moreover that when once a catarrh is properly established the affected person’s breath is infectious, in the acute stage of the disease at least. What then is the nature of the affection? (1) Is it a specific poison comparable to that of the infectious fevers? (2) Does the affection start as an idiopathic inflammation and develop a specific poison which is given off by the breath? (3) Is it of nervous reflex origin purely?

Burger has discovered micrococci in catarrhal secretions, and they are possibly factors in the affection. Let us suppose that these micrococci or their spores are distributed nearly universally in the atmosphere, and are carried in fomites. Let us suppose them in their usual state to be unable to attack the healthy buccal, nasal, or other mucous membranes. Let us presume that there is a condition in which the trophic nerves of those membranes become depressed and lose their tonic action by the action of poor blood, or from the periodical neurasthenia of hereditary neurotics. Here the result of section of the trigeminus on the eye is recalled to one’s mind, and the fact pointed out by Snellen that ophthalmia did not ensue if the eye was carefully covered with cotton-wool, thereby to a great extent excluding micro-organisms, before the nerve section was made. Let us suppose that by feeding in such pastures the progeny of the attacking micrococci become so virulent as to be able to attack successfully the healthy membranes. We know by Pasteur’s experiments the intensive effects of culture on some micro-organisms. On these not unreasonable suppositions then all the peculiarities of catarrhs are explainable.

Influenza epidemics would be explained by supposing that within large tracts of country all catarrhal micrococci became suddenly virulent

owing to some climatic or telluric fostering cause, or to some law of heredity or evolution of the organisms themselves. This would account for the extensive and sudden outbreaks which, on first view, seem so surprising.

The usual "coddling" treatment of colds, except in the very old, very young, or very delicate, is a mistake. A person suffering from a catarrh should certainly be warmly clothed and avoid draughts; but by shutting himself up in a warm room, by taking warm air baths and lowering medicines, he only promotes the development of the exciting cause of the affection.

"Feed a cold, starve a fever." There is a deal of wisdom in the first part of this advice. A person with a catarrh should take an abundance of light, nutritious food, and some light wine, but avoid spirits, and above all tobacco.

Now as to medicines. All depressants should be avoided. For some time I was in the habit of taking a mixture recommended by Dr. Jules Styrap, composed of minute doses of morphine, antimonial wine, and potassium citrate. This beyond doubt always subdued the acute inflammatory stage, but I have no hesitation in saying I was depressed by its action, and rendered liable to relapses and renewals. Personally I have found the large dose of an opiate in the early stages, as extolled by Sir Thomas Watson and Dr. George Johnson, very unpleasant and of but little use.

Trying to avert an attack by a large dose of potassium iodide failed in my hands. The bromides were useless through all stages. Antiseptic inhalations and spraying afforded temporary relief from the distressing symptoms, but failed to cure.

Belladonna, quinine, and arsenic I have found useful when given separately—not so much in large as in small doses. When combined I believe them to be nearly specific—prophylactically and therapeutically, if I may so speak.

The formula I invariably use is as follows:—

R. Quininæ sulphatis, ... gr. xviii;
 Liquoris arsenicalis, ... ℥xij;
 Liquoris atropinæ, ... ℥j;
 Extracti gentianæ, ... gr. xx.
 Pulveris gummi acaciæ, q. s. ut fiant pilulæ xii.

SIG. One every three, four, or six hours according to circumstances.
 If these pills be commenced in the early stage of a common cold, *i.*

c. when the affection is as yet confined to the nose and pharynx, the affection will be nipped in the bud. At starting one pill should be taken every three or four hours, and later on every six. If a catarrhal subject has a box of these pills always at hand, he has, I believe, a weapon wherewith to meet and defeat his enemy. The longest time I have seen a cold last whilst the patient was fairly taking these pills was three days. How the remedy acts I do not know, except it be as a powerful nervine and general tonic, bracing the patient's tissues up to resist the attacks of the exciting cause of the affection.

INJURIOUS EFFECTS OF BLISTERS.—Dr. Wyss of Geneva, has published a warning against the use of blisters. He says that, although devoid of real remedial properties, they are still daily prescribed, perhaps more with the view of sustaining the hopes and confidence of the patient, and of gaining time for the natural process of recovery, than in the expectation of actual benefit. The long experience of an extensive practice leads him to consider blisters an unnecessary cruelty to the patients, which ought entirely to be discarded. He has employed blisters in the treatment of pneumonia, pleurisy, sciatica, and other diseases, but failed in ever observing the slightest benefit from their use. On the contrary, he found them more or less injurious. He thinks that blisters disturb the sleep of the patient in want of restorative rest; they impair in many irritable patients the urinary organs, and they frequently bring on obstinate cutaneous eruptions. Moreover, they cause actual harm by almost invariably increasing the fever in already feverish patients, and may thus seriously affect the general condition.—*Der Fortschritt*,—*Med. Record*.

NINE HOURS' ARTIFICIAL RESPIRATION.—Reports from Ceylon contain an interesting description of recovery of consciousness of the taxidermist of the Victoria Museum, who was bitten by a cobra, which he thought harmless, from previous extraction of the poison bag. For a few moments after the bite he took no heed of it, but pain and nausea were soon set up. Carbolic acid was then applied, ligatures were then bound round the arm, an incision was made at the bite, and the blood of the arm was wholly removed. Various antidotes were used, but the unfortunate man lost the power of speech, and soon every muscle became paralyzed, and respiration ceased. Artificial respiration was then resorted to, and this operation was unceasingly continued for nine hours, when at last the patient made an attempt to breathe, and soon regained consciousness enough to make his wants known. He steadily improved until Fri-

day, the accident having taken place on Wednesday, and then astonished those-around him by stating he was conscious of all that had been taking place, but was unable to make his feelings known, not having the power to move a muscle.—*Medical Press and Circular*.—*Med. Record*.

COCA AS A CARDIAC TONIC, IN HEART STRAIN AND WEAK HEART.—(Beverly Robinson, M. D., in *N. Y. Med. Record*.)—On several occasions, when digitalis has proved to be useless or injurious, I have had very excellent results from caffeine or convallaria. Certainly, the latter drug is more easily tolerated by a sensitive stomach than digitalis is; and whenever the nervous supply of the heart is especially implicated, I believe that I secure more quieting effects from its employment. Among well known cardiac tonics and stimulants for obtaining temporary good effects, at least, I know of no drug quite equal to Coca. Given in the form of wine or fluid extract, it does much, at times, to restore the heart-muscle to its former tone. I have obtained the best effects from the use of Mariani's Wine. From personal information given me by this reliable pharmacist, these results are attributable to the excellent quality of the Coca leaves and of the wine which he uses in its manufacture.

NERVOUS COUGH.—Prof. Bartholow:

R. Acid hydrocyanici dil.,.....3 j.
Tinct. sanguinariae,.....3 ss.
Syr. senegae,.....3 iv.
Aquae lauro cerasi,.....3 vij.
Syr. tolu,.....3 ij.

BRIGHT'S DISEASE.—Professor Dieulafoy says, in relation to Bright's disease, that the nice points that authors try to make as to the particular form of lesion that exists in any given case will fail you generally at the bedside. That, in fact, all the different lesions are often found in the same kidney, and as to which one predominates is a point that can only be determined with certainty by a post-mortem examination. His treatment all resolved itself into a milk diet and blood-letting. He insists on blood-letting whenever the patient presents any symptoms that portend uremic convulsions. Professor Jaccoud's treatment is the same, in addition to which he is now using the inhalation of oxygen gas. He says that the number of casts or the amount of albumen in a given case he considers of less importance in a prognostic point of view than the specific gravity of the urine.—*Paris Correspondent of the Chicago Medical Journal*.

HYPODERMIC INJECTION OF LISTERINE.—It seems strange that at this late day any observing physician should need to be told "How to use Listerine." There is, however, one mode of its administration to which attention may yet be called. I allude to its hypodermic administration. Keeping in view the fact that it is antiseptic, tonic, non-toxic, its use is indicated in all cases of too rapid retrograde metamorphosis, or of deficiency (or perversion) of vital force. During the past four years I have proved this to my complete satisfaction. For the past four months this section has been scourged with a severe epidemic of dysentery and cholera infantum. I have used Listerine, wherever indicated, by the mouth, by rectal injection and hypodermically, and the latter method has always yielded the best results. One case from many similar ones in my call book will illustrate. Jessie —, aged 6 months, suffering with cholera infantum three weeks, has taken many large doses of calomel, quinine, soothing syrup, etc., much emaciated, dejections have an exceedingly bad smell. Surface cold and clammy, pulse rapid and very weak, stomach very irritable, can not retain the Listerine, no matter how much diluted, rectal injections do only temporary good. I apply external warmth, give hypodermically a half drachm of 50 per cent. solution of Listerine in rosewater; in an hour word comes that the baby is better; in six hours I repeat the injection, in twelve hours change for the better is so decided that I can give the remedy by the mouth, diluted with breast milk. It was made as strong as the child could take it. With this and good nourishment and care baby rapidly convalesced. In dysentery, typho-malarial fever, chronic "chills," phthisis, etc., whenever the pulse is rapid and weak, where a vital tonic and antiseptic is indicated, I have always used it hypodermically with positive good results. Given a case where nature seems to be overcome by a poison which she can not eliminate with sufficient rapidity, give Listerine hypodermically, if needed, aid or stimulate the kidneys, bowels or skin, and the Listerine will soon manifest its power in a very positive manner.—F. A. REW, M. D., Portia, Ark., in *Medical Bulletin*.

A NEW REMEDY FOR BURNS.—I was recently called in haste to a little child who was badly burned about the face and hands from falling on a hot stove. The burns were deep, the pain excessive, and the shock, very considerable. I hastily sent to the drug store for a mixture of lime water, olive oil and carbolic acid. While waiting for this I prepared to give the child a hypodermic injection of morphine to allay the agony, which was so great that convulsions seemed imminent. While I was get-

ting ready to do this I espied upon the shelf a bottle of *pinus canadensis* (colorless) which I had some time before ordered to be diluted as a vaginal wash for the mother. Remembering its wonderful soothing influence in acute inflammations of the vagina, I at once concluded to try it. Taking a corner of a soft handkerchief I rapidly painted the injured parts, when like magic the pain ceased. You can well imagine my surprise and delight at the result. I directed a camel's hair brush to be purchased, and had the mother make free applications, and the case had no other treatment save a little iodoform ointment later on. Since this I have tried it in several cases, both slight and severe, with the same delightful results. The preparation was made by the Rio Chemical Co. of St. Louis, Mo.—W. C. WILE, M. D., in *Medical Register*.

SOOTHING MIXTURE FOR CONSUMPTION.—Of all the mixtures for stimulating the consumptive patient, allaying his cough and quieting his nervousness, I have found none equal to the following:

R. Syrup liquorice root..... $\frac{3}{4}$ j.
 Aromatic syrup rhubarb..... $\frac{3}{4}$ ss.
 Fluid extract of opium..... $\frac{3}{4}$ j.
 Liquor ammon. acetat..... $\frac{3}{4}$ v. M.

SIG.—Shake well. Dose—A tablespoonful every two or three hours.

Patients become very fond of this mixture, and it in no wise interferes with the stomach or appetite. Should constipation ensue it is easily overcome by an occasional dose of comp. liquorice powder.—(J. B. JOHNSON, in *Med. and Surg. Reporter*.)

TRITURATION OF ELATERINE.—Physicians should not trust commercial elaterium which is very unreliable, but in administering the active principle, elaterine, which is one of the best purgatives, the official trituration ought to be used:

R Elaterini crystallati.....gr. j
 Sacchari lactis.....gr. ix

M. et triturat. bene. Sig. Dose from one-eighth grain to one grain. Clutterbuck's elaterium is prescribed by some physicians under the impression that it is better than the commercial, and it is still quoted in the price lists. Formerly this brand was perfectly reliable, but Dr. Clutterbuck died in 1856, and now the preparation bearing his name is just as variable as any other. Care must be taken not to confound the crude drug elaterium and its active principle elaterine, as grave results might obtain. The latter only should be employed in medicine.—*Kansas City Med. Index*.

AN OINTMENT FOR OBSTINATE ACNE.—The following is known as Wilkinson's ointment:

R. Naphthol	32½.
Sulphur. precipitat.	312½.
Vaseline or lanoline, ...	
Potassium soap	aa 36¼.
M: ft. unguentum	
SIG.—Local use daily.	

—*Revue de Therapeutique.*—*Med. News.*

THE PHARMACOPEIAS OF THE WORLD.—The number of drugs and preparations officially included in the pharmacopeias of different nations at the present time are as follows, commencing with the highest number. China, however, is not included in the list, being doubtful whether she enjoys the distinction of an official pharmacopeia at all:

Countries.	Number of Official Drugs and Preparations.
1 France.....	2,000
2 Belgium.....	1,500
8 Spain.....	1,500
4 Russia	1,080
5 Greece	1,040
6 Switzerland.....	1,040
7 United States.....	1,010
8 Great Britain.....	815
9 Sweden	746
10 Denmark.....	720
11 Holland.....	665
12 Germany.....	606
13 Austria	560
14 Hungary.....	546
15 Romania.....	546
16 Norway.....	530

—*New Idea.*

INTESTINAL CONCRETIONS RESEMBLING SAND, AND ORIGINATING IN CELLS FROM THE BANANA.—Dr. N. L. Bates describes in the April number of *The American Journal of the Medical Sciences* some peculiar intestinal concretions, resembling fine Mack sand, observed in three cases, which at the time proved very puzzling to himself, as well as to a number of able chemists, microscopists and physicians to whom they had been shown from time to time. They were finally identified as the cells of the banana fruit. Dr. Bates is disposed to regard a prolonged stay in the

intestines as necessary for the development of the deep color, hard, sharp and gritty character, high specific gravity, and siliceous contents of these cells, and when thus developed, they are no more innocent in the bowel than would be a corresponding quantity of sharp sand.

[We were recently consulted by a physican in regard to some curious thread-like bodies passed in the stools of an infant patient. The foreign bodies looked like pieces of doubled black thread, about an inch long, or, on closer observation, rather like strings of very fine black beads. They had been regarded as either the eggs or feces of some intestinal parasite, and santonine had accordingly been given. Microscopical examination showed them to be vegetable, and to answer perfectly to the description given by Dr. Bates. Inquiry revealed, as predicted, that the infant had been fed freely of banana.—EDITOR COL. MED. JOUR.]

WAKING NUMBNESS.—In the current number of *The Amer. Jour. of the Med. Sciences*, Dr. Andrew H. Smith describes a curious neurosis characterized by numbness on waking, either general or confined to the distribution of the ulnar nerves. Two of the four cases which he reports had been subjects of organic nerve lesion, but in the others there was no disturbance of motion, and the abnormal sensation seemed purely subjective. The duration was rarely more than a few minutes, though in one case it lasted sometimes for an hour or two. The condition is not serious, and is met with in hysterical or debilitated persons. Dr. Smith is apparently not aware that Dr. Weir Mitchell described the affection some years ago in his lecture on "Diseases of the Nervous System," in which he states that "in the more usual cases the sleeper awakens with numbness, or rather tingling and numbness, of one arm or of a leg only, which is unfrequent, or the whole side, including the face, and even the tongue, which is now and then attacked alone. The disorder may be mere tingling, or actual loss, or rather lessening of tactile sensation; but in any case it rapidly fades away or yields to a little friction."

In an interesting article on "Local Numbness," in the *Lancet* of Dec. 4, 1886, Dr. J. E. Squire gives several cases in which numbness was a characteristic feature on awakening.

Local treatment does not appear to be of service, but measures calculated to improve the general health usually cause a disappearance of the unpleasant symptoms.—*Med. News.*

COLUMBUS MEDICAL JOURNAL.

EDITORIAL.

HEALTH vs. HEATING AND VENTILATION.

The heating and ventilation of our houses has so much to do with the health and comfort of the inmates that it surprises us that it receives so little attention. With the proper appliances used, the vitiated or foul air is removed, and a supply of fresh admitted, but when such precaution is ignored, the germs of disease gain an easy foothold, and scarlet fever, diphtheria, and other kindred maladies assume a malignant type. Parties building would do well to dispense if necessary with some extravagant ornamentation, and supply their homes with a good hot-water heating apparatus, such as that brought out by Mr. Samuel D. Tompkins, engineer, and manufactured by the A. A. Griffing Iron Co., 518 Communipaw ave., Jersey City, N. J., which meets all the conditions required; *i. e.*, cheapness, durability and effectiveness; the latter, however, being the most prominent. On application the A. A. Griffing Iron Co. will send their handsome illustrated circulars, both of hot water heating and ventilating apparatus, and their numerous constructions for steam uses, and those who may be building, or about to build, would do well to consult the above firm before purchasing heating appliances.

Fluid Forms of Hydrastis.

The reputation of this drug as a therapeutic agent was first gained through its employment in the form of an *infusion*; and in the fifty years following its introduction into medical practice, a continuous effort has been made by manufacturers to perfect a preparation which would represent all the active principles of the drug, without the high price of the salts, either alone or in combination.

The most prejudiced writers on *Materia Medica*, accord to the late Wm. S. Merrell the largest share of credit in the introduction of Hydrastis preparations, and to the present organization the reputation of being the *largest consumers of the drug in the world*. For more than a half-century, Hydrastis has been made a study in our laboratory, and we do not think we exaggerate its importance when we assert that it stands pre-eminent to-day as the most valuable exponent of our vegetable *Materia Medica*.

The following preparations in *fluid form* are receiving our special attention at this time :

Fluid Hydrastis—MERRELL.

Is what its name implies—the active, medicinal principles of the drug in natural combination and in a fluid form. It has a bright, yellow color, perfectly clear, free from sediment, and with an unmistakable odor of the *fresh drug*.

Fluid Hydrastis is a pure, neutral solution of all the alkaloidal constituents of the drug, rejecting the oil, gums, irritating and offensive resins and inert extractive matters. The success attending its introduction is the best evidence of its therapeutic value.

Unsuccessful imitations and would-be substitutes are met with on every hand. Preparations said to be “just as good” or “about the same thing,” but always “a little cheaper,” attest the wide-spread and growing popularity of Fluid Hydrastis. All such, compared with the latter as to physical appearance or as representatives of the drug, *are condemned*; dispensed in prescriptions, *they are readily detected*; tested therapeutically, they are *promptly rejected* as unworthy of confidence.

Fluid Hydrastis is applicable to the treatment of all irritable, inflammatory and ulcerative conditions of the mucous tract.

This statement of a well-known medical writer and journalist has become axiomatic:

“No remedy for physician's use has been received with such universal approval.”

Solution Bismuth and Hydrastia—MERRELL.

An invaluable and scientific combination, wherein the beneficial action of the white alkaloid is increased by association with Bismuth. This solution contains $2\frac{1}{2}$ grains of the double Citrate Bismuth and Hydrastia; twenty-five per cent. of which is Hydrastia Citrate.

The cordial reception accorded this preparation marks it as the most valuable combination in the market in which the white alkaloid alone represents the valuable properties of the drug. Used in diseases of the nasal passages, of the eye, of the throat, of the stomach and intestines, of the reproductive organs and bladder it is equally beneficial.

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This is a permanent solution of the white alkaloid, without the addition of any other medicinal agent to modify or increase its action. It is offered without special recommendation to meet the views of an unlimited number of physicians, with whom the color of the Fluid Hydrastis is an objection. This solution contains in one fluid pint the same proportionate strength of white alkaloid as exists in an average quality of crude root.

See notes above on Solution Bismuth and Hydrastia.

“Merrell's Hydrastis Preparations” are for sale by Wholesale Druggists throughout the United States. Please Specify “Wm. S. M. Chem. Co.” in ordering or prescribing.

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CINCINNATI.

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EDITORIAL DEPARTMENT.

J. F. BALDWIN, M. D., Columbus, - - - - EDITOR.

Communications, reports, etc., are solicited from all quarters.

Authors desiring reprints, will receive fifty, free of charge, *provided* the request for the same accompanies the article.

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HANN & ADAIR, Publishers, Columbus, O.

OHIO STATE MEDICAL SOCIETY.—Forty-Second Annual Meeting, at Toledo, Ohio, June 15th, 16th and 17th, 1887. President, Thos. McEbright, Akron.

The following papers are announced:

"The Eyesight and Hearing of Railroad Men." A. R. Baker, Cleveland.

"The Pathogenetic Relationship of Physical Conditions to Insanity." J. A. Wright, Toledo.

"Modus Operandi of Therapeutical Forces." E. Conn, Akron.

"Vaginal Hysterectomy." T. A. Reamy, Cincinnati.

"Reflex Vesical Irritation." J. W. Shively, Kent.

"One Day with Dr. Goodwin." A. E. Foltz, Akron.

"Medical Expert Testimony." F. H. Darby, Morrow.

"The Relation between Tyrotoxon and the Summer Diarrheas of Infancy." V. C. Vaughn, Ann Arbor, Mich. (By invitation.)

"Amputation in Osteo-Cancer of the Limbs—with Cases." S. F. Forbes, Toledo.

"Electrolysis in Dermatology—a few Practical Suggestions." W. T. Corlett, Cleveland.

"Malarial Affections of the Eye." W. W. Seeley, Cincinnati.

"Fractures at the Lower End of the Humerus." S. S. Thorn, Toledo.

"The Management of Persistent Uterine Hemorrhage." A. B. Carpenter, Cleveland.

"Strangulated Hernia." L. S. Ebright, Akron.

"Insanity." J. Strong, Newburg.

"The Management of Eczema Infantile." B. M. Ricketts, Cincinnati.

"The Relations of the Physician to Sanitation." T. C. Miller, Massillon.

"On Pelvic Hematocele, considered as a Consequence of Tubal Pregnancy, with Report of a Case." C. A. L. Reed, Hamilton.

"What are the Laws of Ohio regulating the Practice of Medicine and Surgery? What Additions are needed to protect the People of the State from Impostors?" W. W. Jones, Toledo.

"The Surgical Treatment of Chronic Follicular Pharyngitis." R. Harvey Reed, Mansfield.

"The Treatment of Retained Placenta." B. B. Loughead, Ravenna.

"Phytolacca Decandra." G. A. Collamore, Toledo.

The following Amendments, proposed by Dr. W. B. Davis, Cincinnati, will come up for consideration:

I. "That a Standing Committee be appointed annually to report on the general subjects of Medicine and Surgery respectively."

II. "That candidates for the elective offices, viz: President, Vice Presidents, Secretaries, Treasurer and Standing Committees, be nominated by a general Committee, consisting of a delegate from each county represented in the State Society."

The Sessions of the Society will be held in Memorial Hall, corner of Adams and Ontario Sts: first Session at 2:00 P. M., Wednesday, June 15. There will be no Session on Wednesday and Thursday evenings.

Hotels.—Boody House, \$3.00 and \$3.50; Hotel Madison and Burnett House, \$2.00 and \$2.50; Hotel Union, Merchant's, Jefferson, Oliver and St. James, \$2.00 per day.

Railroads.—Reduced rates may be obtained on the Railroads named below on the following conditions: Each person must purchase a first-class ticket to Toledo; he must obtain from the ticket agent a certificate of such purchase, which agents are instructed to furnish on request; he must have this certificate, signed by the Secretary at the meeting. On presentation of this certificate to ticket agents in Toledo, they are instructed to sell return tickets at *one third the lowest regular limited fare*. Tickets to Toledo should not be purchased more than *three days prior* to the meeting. Certificates are good for *three days after* the meeting, and are *not transferable*. Return tickets are limited to continuous passage on first train after purchase. If through tickets cannot be procured at the

starting point, purchase ticket to most convenient point where they can be procured, and buy ticket and get certificate from ticket agent there.

Railroads granting reduced rates on above plan are: Baltimore & Ohio; Chicago & Atlantic; Chicago, St. Louis & Pittsburgh; Cincinnati, Hamilton & Dayton; Cincinnati & Muskingum Valley; Cincinnati, Washington & Baltimore; Cleveland, Columbus, Cincinnati & Indianapolis; Cleveland; Akron & Columbus; Columbus & Cincinnati Midland; Dayton & Union; Indiana, Bloomington & Western; Lake Erie & Western; Lake Shore & Michigan Southern; New York, Pennsylvania & Ohio; Pennsylvania Co.; Pittsburgh & Lake Erie; Pittsburgh & Western; Pittsburgh, Cincinnati & St. Louis; Scioto Valley; Valley; Wabash, St. Louis & Pacific; Wheeling & Lake Erie; Columbus, Hocking Valley & Toledo.

EXPERT TESTIMONY.—Dr. F. H. Darby, of Morrow, who was sent to jail for refusing to testify as an expert unless compensated therefor, and who took an appeal to the Circuit Court, has recently met with an adverse decision at the hands of that body. The decision was made on technical grounds, and does not touch the real issue.

When we wrote our editorial on this case, in our January issue, we did so under the supposition that Dr. Darby was a pure expert in the case. It now appears, however, that he made the autopsy for the coroner, and was thus a witness as to facts. He testified as to these facts, but refused to give an opinion as to their significance unless paid an expert fee. The issue is not, therefore a simple one, nor just such a one as would be most desirable to carry to the Supreme Court. We are afraid the Doctor would there be defeated, and again on technical grounds.

THE MALPRACTICE SUIT, which is reported in this issue, presents a point of great practical importance to every physician, although arthritis is a somewhat uncommon sequel to hip-joint injuries. That the plaintiff and her advisers were entirely honest in their opinion that a fracture existed, is hardly to be questioned. It is equally unquestionable that they were in error, and that their abandonment of the case was the only proper course to pursue. Dr. Courtright and the profession generally are to be congratulated on the result.

We are personally acquainted with the facts in a probably similar case of hip-joint injury, occurring in the person of the mother of a physician of this city. In this case, however, several months after the development of the arthritis in the injured joint (diagnosed at the time as a "bruise" by the attending physician,) the arthritis became gen-

eral, the patient when seen by the writer, two or three years after presenting the typical aspect of a case of rheumatoid arthritis.

[ERRATA.—In the report of this case, the examination of the plaintiff by Drs. Hamilton, Jones and Warner should have been given as occurring Jan. 25, 1886, instead of 1884; and the date of Dr. Baldwin's second letter should have been April 29, 1886, instead of 1885.]

WE understand that the Toledo brethren propose to give the Society a reception Wednesday evening, and a boat-ride and collation on Thursday evening. These attractions should secure a large and enthusiastic attendance.

THE MEDICAL REGISTER.—This is a new weekly journal, published in Philadelphia, and edited by Drs. Shoemaker and Wile. It starts out in a most vigorous way, and bids fair to prove a formidable rival to the other weeklies. Its editors have both long since won their spurs, and bring long and successful experience to the aid of the new undertaking.

THE INTERNATIONAL MEDICAL CONGRESS, which is to be held in Washington next September, is said by its managers to be in a fair way to come to a successful issue. Details thus far furnished are quite meager. The committee in charge is meeting with no opposition, but everywhere encounters the feeling of distrust incident to the conspicuous absence from the organization of nearly all prominent American physicians and Surgeons.

THE treatment of consumption by gaseous injections is not proving a decided success in America. In this city it has been tried by a number of physicians, but generally with negative results. The quacks have already seized upon it, and in this city one is advertising it as a sure cure in incipient consumption.

DR. JOHN MCCURDY, of Youngstown, read an interesting historical sketch of the origin of health-boards, at the recent sanitary convention at Warren. It is published in full in the *Youngstown Telegram*, so as to reach and educate the masses for whom it was intended.

DR. HENRY LEFFMAN (P. O. Box 791, Philadelphia,) desires to obtain the results of the new treatment of Pulmonary Consumption and Phthisis by gaseous enemata, for publication. The correct therapeutic value of this method can only be arrived at by the collection of statistics, and he therefore requests any one who has administered the gas to com-

municate the result to him, the formula used, and any special information that may be useful.

DR. S. L. McCURDY, of Dennison, has been elected regimental surgeon of the Fifth Regiment, Uniform Rank, K. of P., comprising the Divisions of Eastern Ohio. He ranks as Major, and the position is quite an honor.

DR. D. G. BRINTON, who has been for so many years the editor of the *Medical and Surgical Reporter*, has severed his connection with that journal. He will not retire from the field of journalism which he has so conspicuously ornamented, but will connect himself with some other journal in the early autumn.

DR. P. J. KLINE (Miami Medical, 1871, Bellevue Medical College, 1874,) of Portsmouth, Ohio, is spending a few months in Southern California. The Doctor is an entertaining, scientific gentleman.—*So. Cal. Practitioner*.

SYPHILIS AND LOCOMOTOR ATAXIA.—I am making some investigations as to the frequency of locomotor ataxia in old syphilitics, and, in order to enlarge the field of observation, hereby respectfully request the assistance of my medical brethren.

Physicians, who will kindly assist me in compiling these statistics, are requested, *firstly*, to attempt to recall cases of syphilis which they have treated, (only those cases to be included in which constitutional symptoms have been observed) where the preliminary lesion occurred longer than five years ago; *secondly*, to try to see these patients and find out by a careful examination whether there are any symptoms of locomotor ataxia at the present time. I wish a careful examination made, because, while the prominent symptoms of ataxic gait, etc., may be absent, it may reveal the initial symptoms of that disease. I wish special attention to be paid to (1) whether patient has ever had double vision for a period of time; (2) whether he suffers with lancinating pains; (3) whether the pupils are of equal size and respond to light; and (4) whether the patellar tendon reflex can be elicited.

In testing the patellar tendon reflex it will, usually, be sufficient to ask the patient to cross one knee over the other, when a tap upon the ligamentum patellæ will cause a contraction of the quadriceps femoris and a forward jerk of the foot. But, occasionally the reflex is very difficult to elicit. In that case, before pronouncing it absent, the patient should

be seated on a table so that the feet dangle freely, the knees should be laid entirely bare, and the patellar tendon struck upon every part.

I lay so much stress on this reflex because it is usually the first, and one of the most reliable, symptoms of locomotor ataxia.

In each case reported I would like to have the following data given :

1. Age. 2. Proximate time of initial lesion. 3. The kind and duration of treatment instituted for the syphilitic disease. 4. Prominent constitutional symptoms presented. 5. Mention whether or not there are any symptoms of locomotor ataxia. If there are any such symptoms mention them in full.

In order that statistics may be true all sources of error must be carefully eliminated. I see two sources of inaccuracy in the statistics I am now compiling, both of which can be easily avoided.

The first is this: Physicians can, of course, not recall all the cases of syphilis seen many years ago, and, with the thought of locomotor ataxia in their minds, will more readily recall cases in which the latter disease subsequently developed. The result might be that my statistics would show a larger proportion of cases of locomotor ataxia in old syphilitics than actually occurs. To avoid this source of error I wish physicians would select only such-subjects for examination of whom they do not know, at the time of reading this note, whether they have locomotor ataxia or not. At least I would request that with the report of each case they would append a statement as to their knowledge prior to this time whether patient had this disease or not.

The second possible source of error is this: That physicians will be more likely to report their cases to me if they find locomotor ataxia present than if it be absent, and thereby, again, the proportion of cases of locomotor ataxia be very much increased. To avoid this source of error I must beg physicians not to make any examinations in response to this request unless they intend to report their results, whatever they may be. It must be remembered that these investigations are made, not for the purpose of proving a certain point, but in search of the truth.

As I wish only reports of cases in which the initial syphilis occurred longer than five years ago (it may have been ten, twenty, or it matters not how many years), and in which the patient can be seen for examination now, it is not to be expected that any one physician can report many cases, but single observations will be gratefully received.

It is requested that all reports be made within one month, or two months at the farthest.

PHILIP ZENNER.

335 W. Ninth street, Cincinnati, O.

OBITUARY.

WILLIAM MORROW BEACH, died at his home in London, Ohio, May 5, 1887, of apoplexy.

He was born in Amity, Madison County, Ohio, on the 10th day of May, 1831, and graduated at Starling Medical College in 1853. He practiced his profession at Unionville Centre, then at Lafayette, and finally at London, Ohio, his final place of residence.

He entered the army, in the Civil War, as a State Assistant Surgeon, April 3, 1862; was commissioned Assistant Surgeon of the 78th Regt. Ohio Inf'ty Vols. May 3, 1862, to rank as such from April 20, 1862, and was commissioned Surgeon of the 118th Regt Ohio Inf'ty Vols. May 19, 1864, and served as such to the close of the war.

On the Vicksburgh campaign, he was the Division Hospital Director of General John A. Logan's Division; and at the close of the war was the Division Hospital Director of the 2d Division, 23d Army Corps, and one of the three surgeons that constituted the Division "Operating Board."

He was elected President of the Ohio State Sanitary Association in 1884, and President of the Ohio State Medical Society in 1885.

He filled with honor and distinction all the positions to which he was appointed or elected, and died universally regretted by all his fellow citizens and professional associates.

REVIEWS AND BOOK NOTICES.

Practical Lessons in Nursing. The Nursing and Care of the Nervous and the Insane. By Charles K. Mills, M. D., Professor of Diseases of the Mind and Nervous System in the Philadelphia Polyclinic; Neurologist to the Philadelphia Hospital, etc. 12 mo. pp. 147 Philadelphia: J. B. Lippencott Co. Price \$1.00.

This book contains the substance of the lectures given by the author before the training School for Nurses at Philadelphia. There are many books upon nursing in general, and also upon nursing the insane, but nothing heretofore upon the care of patients suffering from functional or organic nervous troubles not forms of insanity; therefore this publication will serve a most excellent purpose as a guide to the care of a class of troubles always requiring the closest attention and most intelligent watchfulness. A special chapter is devoted to the subjects of massage, move-

